32-000 MENTAL HEALTH AND SUBSTANCE ABUSE TREATMENT SERVICES FOR CHILDREN AND ADOLESCENTS

32-001 Introduction: Effective July 1, 1995, NMAP covers Mental Health and Substance Abuse Services for Children and Adolescents for clients age 20 and younger as part of the HEALTH CHECK (EPSDT) program. HEALTH CHECK (EPSDT) follow-up services are those necessary to diagnose or treat a condition identified during a HEALTH CHECK screening examination and are covered under conditions outlined in 471 NAC 33-001.03 (Definition of Services).

The client must participate in a HEALTH CHECK (EPSDT) Screen either within six months prior to the initiation of mental or substance abuse health services or within eight weeks after the initiation of mental health or substance abuse services. If a client is already participating in mental health or substance abuse care reimbursed by NMAP at the time this policy becomes effective, the client must participate in a HEALTH CHECK (EPSDT) Screen within six months of the effective date of this policy. Reimbursement for services to clients who do not meet these requirements will not be available.

Mental health and substance abuse services (MH/SA) are provided as a managed care benefit for all Nebraska Medicaid Managed Care (NMMCP) clients. The benefit includes the Client Assistance Program (CAP). Clients may access five services annually with any CAP-enrolled provider without prior authorization. All other MH/SA services must be prior authorized.

NMAP covers these services under 1905(r) of the Social Security Act.

The Department's philosophy is that all care provided to clients must be provided at the least restrictive and most appropriate level of care. Care must be family-centered, community-based, developmentally appropriate, and culturally competent and must take into account the individual needs of clients age 20 and younger. More restrictive levels of care will be used only when all resources have been explored and have been deemed inappropriate. The services provided must be rehabilitative, not habilitative in nature.

Providers must encourage family members to be involved in the assessment of the client, the development of the treatment plan, and all aspects of the client's treatment unless prohibited by the client, through legal action, or because of federal confidentiality laws.

The following mental health and substance abuse services may be covered by NMAP when the client participates in a HEALTH CHECK (EPSDT), the services are medically necessary, and the level of care needed is identified during a pre-treatment assessment:

1. Outpatient Mental Health or Substance Abuse Treatment;
2. Treatment Crisis Intervention;
3. Day Treatment;
4. Treatment Foster Care;
5. Treatment Group Home;
6. Residential Treatment; and
7. Inpatient Hospital Services and Inpatient Services provided in an IMD.

These services are arranged from the least restrictive and least intensive (outpatient care) to the most restrictive and most intensive (inpatient care).

Providers of mental health and substance abuse services to children and adolescents must obtain the informed consent of the client's parent or guardian prior to the initiation of services or when there is a change in the services. If a client is a ward of the Department, the Department case manager must provide all consents to treat and informed consent. This in no way precludes the provider's responsibility to work with the client's family.

Clients are best served by family-centered, culturally competent, and community-based programs that focus on returning the client to the home community as quickly as possible. By working with the family on a frequent and intense basis, lengths of stay can be decreased as can the overall involvement in the treatment system. Placing a child outside of his/her community does not facilitate this goal. It is the philosophy of the Department that all clients should be treated within their home communities.

Children age ten and under need specialized care when placed outside of their homes or away from families, especially when this is in an inpatient hospital setting. These clients require more supervision, more nurturing, and shorter lengths of stay. It is the philosophy of the Department that hospitalization should only be considered if only a brief inpatient stay could stabilize the client's serious emotional disturbance.

It is the philosophy of the Department that children age six and under are difficult to serve adequately in an out-of-home setting. The needs for attachment to a caretaker and nurturing can be sabotaged by an out-of-home treatment setting and this may cause further problems. With young children, the preferred intervention should always be in-home services.

The Department does not identify the initiation of medication as the exclusive treatment intervention for children or adolescents experiencing a mental health or substance abuse problem. Psychotropic medications should be used as part of an overall treatment plan to intervene on the client's symptoms, and never as the only intervention. When initiating medication, the physician should start with the lowest dose recommended and slowly increase the dose to a therapeutic level. If a client's condition requires the use of multiple medications, it is the philosophy of the Department that this be monitored closely to avoid dangerous or prolonged side effects.

If a client is age ten or under, it is the philosophy of the Department that there should be an even more conservative response to the use of medications. The use of medication should be monitored on a frequent basis and discontinued if it is not having the desired effects.

The Department recognizes that children and adolescents experience a multitude of problems. If a client has a primary psychiatric diagnosis in addition to substance abuse issues, dual diagnosis treatment may be most appropriate. Dual diagnosis services are defined as the simultaneous and integrated treatment of coexisting disorders. This includes, but is not limited to, substance abuse and mental health disorders. Programs that wish to provide dual diagnosis treatment programs must meet the standards set in each subpart for the appropriate level of care.

For services in this chapter to be covered by NMAP, clinical necessity shall be established through an assessment (see 471 NAC 32-001.01, Assessment). For services in this chapter to be covered by NMAP, the client must have a diagnosable mental health or substance abuse disorder of sufficient duration to meet diagnostic criteria specified within the current Diagnostic and Statistics Manual of the American Psychiatric Association that results in functional impairment which substantially interferes with or limits the person's role or functioning within the family, school, or community. This does not include V-codes or developmental disorders.

32-001.01 Pre-Treatment Assessment (Biopsychosocial Assessment and Initial Diagnostic Interview): This assessment is used to identify the problems and needs, develop goals and objectives, and determine appropriate strategies and methods of intervention for the client. This comprehensive plan of care will be outlined in the individualized treatment plan and should reflect an understanding of how the individual's particular issues will be addressed with the service. The assessment must occur prior to the initiation of treatment interventions and must include a baseline of the client's current functioning and treatment needs. Providers must encourage families to actively participate in the pretreatment assessment. (EXCEPTION: Clients receiving treatment crisis intervention or inpatient hospital services for the first time are not required to receive a pre-treatment assessment before services are initiated. Providers of the above-mentioned services must facilitate or perform the pre-treatment assessment.) The Biopsychosocial Assessment must be completed by a staff person, acting within his/her scope of practice, who is enrolled as a provider of Mental Health Services for Children and Adolescents. The staff person is responsible for gathering the information included on the assessment through direct face-to-face interview (with the family) and the comprehensive review of the client's past records. The licensed practitioner of the healing arts who is able to diagnose and treat major mental illness within his/her scope of practice must complete an Initial Diagnostic Interview as defined in each chapter. The recommendations must be developed by the practitioners and the practitioners must sign the assessment. Licensed practitioners who are able to practice independently under their scope of practice must provide a comprehensive mental health/substance abuse assessment which must include all of the components of a biopsychosocial assessment and initial diagnostic interview. (See fee schedule for the appropriate code and modifier). The assessment must include, to the degree deemed clinically appropriate by the qualified mental health professional, the following information:

Biopsychosocial Assessment

1. Presenting Problem and Goals as Described by:
   a. Client;
   b. Family;
   c. Others;
2. Social History:
   a. Environmental influences (moves and reasons, housing conditions);
3. Family Dynamics:
   a. Demographic and historical information;
   b. Divorces, separations, deaths, and incarcerations of parents and significant others (include reasons);
   c. Parent and family vocational history;
   d. Parent and family treatment history;
4. Mental Health History:
   a. Symptoms;
   b. Diagnoses;
   c. Treatment interventions including psychotropic medications (outcome);

5. Academic and Intellectual History:
   a. Academic history;
   b. Most recent IQ and historical;
   c. Learning disabilities, behavior disorders, or impairment;
   d. Interventions and outcomes;
   e. Vocational history or training;
6. Medical History:
   a. Physical development;
   b. Prenatal, birth, development milestones;
   c. History of injuries and illnesses, handicapping conditions;
   d. Chronic medical conditions and medications taken;
   e. Sexual development, menstrual history, pregnancies, births, or fathered children;
7. Legal History:
   a. Offenses against the client;
   b. History and current legal status;
8. Offender Issues;
   a. Status Offenses;
   b. Violence to property;
   c. Violence and assault to others;
   d. Other;
9. Victim Issue:
   a. Physical Abuse;
   b. Sexual Abuse;
   c. Emotional Abuse;
   d. Neglect;
   e. Other;
10. Substance Abuse History;
    a. Client use;
    b. Family history;
    c. Treatment history; and
11. Personal Assets and Liabilities.

Initial Diagnostic Interview

1. Psychiatric evaluation with mental status exam and diagnosis;
2. Recommendations:
   a. Treatment needs and recommended interventions for client and family;
   b. Identification of who needs to be involved in the client's treatment;
   c. Overall plan to meet the treatment needs of the client including transitioning to lower levels of care and discharge planning;
   d. A means to evaluate the client's progress throughout their treatment and outcome measures at discharge;
   e. Recommended linkages with other community resources;
   f. Other areas that may need further evaluation.

Pre-treatment assessments that are incomplete or do not include the initial diagnostic interview assessment will not be reimbursable.

32-001.01A Involvement of the Supervising Practitioner: The supervising practitioner (see 471 NAC 32-001.04) must meet face to face with the client within four weeks of the initial session with the therapist or sooner if necessary. The supervising practitioner must complete a mental status exam and diagnosis, at a minimum. This functions as the initial assessment by the supervising practitioner. The supervising practitioner must work with the therapist to develop the recommendations. The supervising practitioner must sign the assessment document.

32-001.01B Payment for Assessments: Payment for assessments outlined in the previous section is made according to the Nebraska Medicaid Practitioner Fee Schedule in 471-000-532. Therapists shall use national standard code sets to bill for Biopsychosocial Assessment functions provided by the clinical staff person and Initial Diagnostic Assessment provided by the supervising practitioner. The reimbursement for these code sets includes interview time, documentation review, and the writing of the report and recommendations.

The assessment must address each area listed in this section to be eligible for reimbursement.

Providers of the pre-treatment assessment shall bill for the entire assessment (Assessment and Initial Diagnostic Interview) at one time and on claim form CMS-1500 or the standard electronic Health Care Claim: Professional transaction (ASC X12N 837). The completed pre-treatment assessment must be included in the client file and available for review upon request. Failure to produce a completed pre-treatment assessment upon request, or lack of inclusion in the client file determined during review, shall be cause for claim denial and/or refund request.

NMAP will provide reimbursement for one pre-treatment assessment per treatment episode. Addendums may be included if additional information becomes available. If the client remains involved continuously in treatment for more than one year, reimbursement for a pre-treatment assessment will be available annually. If the client leaves treatment prior to a successful discharge and returns for further treatment, the provider must assess the need for an addendum or a new assessment. A second pre-treatment assessment within a year must be prior authorized. Practitioners shall use national standard code sets to bill for this activity. Prior authorization is obtained through the Division of Medicaid and Long-Term Care or their designee.

For further instructions on billing for outpatient mental health and substance abuse services, please see 471 NAC 32-002.11 and 471 NAC 32-002.12.

32-001.01C Procedure Codes and Description for Pre-Treatment Assessments: HCPCS/CPT procedure codes used by NMAP are listed in the Nebraska Medicaid Practitioner Fee Schedule (471-000-532).

32-001.01D Distribution of the Pre-Treatment Assessment: Providers must distribute complete copies of the pre-treatment assessment to other treatment providers in a timely manner when the information is necessary for a referral and the appropriate releases of information are secured.

32-001.02 Medical Necessity Statement: Medical necessity is defined as the need for treatment services which are necessary to diagnosis, treat, cure, or prevent an illness, or which may reasonably be expected to relieve pain, improve health, or be essential to life. Medical necessity is relative to community standards of intervention. Prior authorization through the Division of Medicaid and Long-Term Care may be required for treatment. Clients receiving these services must have a diagnosable mental health or substance abuse condition and be experiencing functional impairments as a result of this condition. Biopsychosocially necessary treatment interventions and supplies are those which are:

1. Consistent with the behavioral health condition and conducted with the treatment of the clients as the primary concern;
2. Supported by sufficient evidence to draw conclusions about the treatment intervention's effects of behavioral health outcomes;
3. Supported by evidence demonstrating the treatment intervention can be expected to produce its intended effects on behavioral health outcomes;
4. Supported by evidence demonstrating the intervention's intended beneficial effects on behavioral health outcomes outweigh its expected harmful effects;
5. Cost effective in addressing the behavioral health outcome;
6. Determined by the presentation of behavioral health conditions, not necessarily by the credentials of the service provider;
7. Not primarily for the convenience of the client or the provider; and
8. Delivered in the least restrictive setting that will produce the desired results in accordance with the needs of the client.

Behavioral health conditions are the diagnosis listed in the current version of the Diagnostic and Statistic Manual as published by the American Psychiatric Association. (The NMAP does not reimburse for services for diagnoses of developmental disabilities, mental retardation, or V codes as part of this chapter.)

Behavioral health outcomes mean improving adaptive ability, preventing relapse or decomposition, stabilization in an emergency situation, or resolving symptoms.

A client must meet medical necessity criteria to be eligible for any of the Mental Health or Substance Abuse Services. A supervising practitioner shall establish that the client meets eligibility criteria for a particular service through a face-to-face assessment before the client is admitted for treatment. A statement of medical necessity must be completed by the supervising practitioner and provided to the treatment provider each time the client is admitted or readmitted for services.

The statement of medical necessity establishes the level of care the client requires, identifies current problem areas that need to be addressed by the treatment provider, and provides documentation that care has been recommended by a physician or licensed psychologist. The statement of medical necessity must be completed prior to or at the time of admission and must be placed in the initial treatment plan and clinical record.

32-001.02A Supervising Practitioner: NMAP has designated clinical supervisory responsibilities to professionals considered by the Nebraska Department of Health and Human Services, Division of Public Health as licensed practitioners who are able to diagnose and treat major mental illness within their scope of practice:

1. Licensed physician;
2. Licensed doctor of osteopath;
3. Licensed psychologist; and
4. Licensed independent mental health practitioners (effective December 1, 2008 and after).

These professionals are designated as supervising practitioners for mental health/substance abuse services.

32-001.02B Definition and Practice of Supervision: Supervision by the supervising practitioner is defined as the critical oversight of a treatment activity or course of action. In addition to providing a initial psychiatric diagnostic assessment, supervision includes, but is not limited to, review of treatment plan and progress notes, client specific case discussion, periodic assessments of the client (as defined in each section), and diagnosis, treatment intervention or issue specific discussion. The supervising practitioner is a source of information and guidance for all members of the treatment team and their participation in services as an essential ingredient for all members of the treatment. The critical involvement of the supervising practitioner must be reflected in the pre-treatment assessment, the treatment plan, and the interventions provided.

The supervising practitioner (or their designated and qualified substitute) must be available, in person or by telephone, to provide assistance and direction as needed during the time the services are being provided.

Supervisory contact may occur in a group setting.

Supervision is not billable by either the therapist or the supervising practitioner as it is considered a mandatory component of the care.

Psychiatric resident physicians and physician extenders may not supervise allied health therapists for NMAP services.

The supervising practitioner shall periodically evaluate the therapeutic program and determine if treatment goals are being met and if changes in direction or emphasis are needed.

32-001.03 Standards For Participation For Providers of Mental Health and Substance Abuse Services For Children and Adolescents

32-001.03A Provider Agreement: A provider of mental health and substance abuse services for children and adolescents shall complete Form MC-19 or Form MC-20, "Medical Assistance Provider Agreement," and submit the completed form to the Department for approval. Specific requirements for each specialized mental health treatment and substance abuse service are listed in the respective subpart. The provider must meet all of these standards in order to be enrolled with NMAP. The Department is the sole determiner of which providers are approved for participation in this program. The provider will be advised in writing when its participation is approved. (A separate application must be submitted for each specialized mental health and substance abuse treatment service and each service will be approved separately.)

Refer to the Standards for Participation section in each subpart.

Providers are responsible for verifying that their employees are appropriately licensed or certified through the Nebraska Department of Health and Human Services, Division of Public Health for the appropriate scope of practice.

32-001.03B Provider Enrollment Status: The provider enrollment process allows for three types of provider enrollment status based on information from the provider and other sources. The Department shall notify the provider of the status assigned. The types of provider enrollment are -

1. Provisional status: A provider who has recently established services within this chapter or who is new to the NMAP will be enrolled with a provisional status. After a minimum of one year of services, the Department may choose to grant ongoing status to the provider.
   a. Grounds for terminating a provider agreement are further defined in 471 NAC 2-002.03, "Reasons for Sanctions."
   b. Providers may appeal the decision to terminate a provider enrollment. The appeal process is described in 471 NAC 2-003, "Provider Hearings."
2. Ongoing status: A provider may establish ongoing status after a minimum of one year of service within the NMAP guidelines.

3. Probationary status: A provider may be placed on probationary status when there are deficiencies in meeting NMAP guidelines or there are other concerns about the provider's program or practices. While on probationary status, a provider may be required to work with Medicaid staff to develop a corrective action plan. This plan shall be submitted to Medicaid staff for approval.
   a. Grounds for terminating a provider agreement are further defined in 471 NAC 2-002.03, "Reasons for Sanctions."
   b. Providers may appeal the decision to place a provider on probationary status. The appeal process is described in 471 NAC 2-003, "Provider Hearings."
   c. The probationary status will be evaluated by Medicaid staff on a frequency based on the situation. At these evaluations, a provider's enrollment may be terminated, placed on further probation, or returned to ongoing status. Providers may appeal these decisions as described in 471 NAC 2-003, "Provider Hearings."
   d. If the deficiencies are not causing immediate jeopardy or compromising the safety of the clients, then the facility can continue to participate in NMAP. A prohibition of new admissions may occur if -
      (1) There are allegations of abuse or neglect under investigation in relation to the program or its staff;
      (2) The quality of treatment is significantly compromised by the deficiencies; or
      (3) The provider is violating any laws, regulations, or code of ethics governing their program.

32-001.03C Updates: The provider shall send to the Department an update of the services provided in its facility and the current list of staff each year during the anniversary quarter of the provider's enrollment in NMAP as a provider of mental health or substance abuse services for children and adolescents. This information shall also be sent to the Department if a provider makes changes in how they provide a service. These changes and updates must be indicated on Form MC-19 or Form MC-20, "Medical Assistance Provider Agreement."

32-001.04 Staffing Standards: A provider of mental health and substance abuse services for children and adolescents shall meet the following standards to participate in NMAP:

1. The treatment plan must be developed and the intervention services must be implemented under the clinical supervision of a licensed practitioner of the healing arts who is able to diagnose and treat major mental illness within his/her scope of practice. This position will be referred to as the Supervising Practitioner in these regulations. This designation includes -
   a. A licensed physician;
   b. A licensed doctor of osteopathy;
   c. A licensed psychologist; and
   d. A licensed independent mental health practitioner (effective December 1, 2008 and after).
2. Physician extenders may provide direct care as allowed by the scope of practice guidelines set by the Nebraska Department of Health and Human Services, Division of Public Health and the practice agreement of each individual. A copy of the practice agreement must be submitted at the time of enrollment. Physician extenders include physician assistants and nurse practitioners. For NMAP purposes, psychiatrically trained physician extenders may not supervise services in place of a psychiatrist or physician.
3. Licensed Independent Mental Health Practitioners (LIMHP) may provide direct care as allowed by the scope of practice guidelines set by Nebraska Department of Health and Human Services, Division of Public Health.
4. Services must be rendered by a supervising practitioner, a physician extender, a Licensed Independent Mental Health Practitioner or by a clinical staff person under the direction of a supervising practitioner. Services must be provided within the scope of practice and licensure guidelines established by Nebraska Department of Health and Human Services, Division of Public Health or the state in which the service is rendered.

   For NMAP purposes in this chapter, "qualified" is defined as a person who has specific training in providing mental health or substance abuse services within their scope of practice. For NMAP purposes, the following professionals qualify as clinical staff for mental health or substance abuse services for children and adolescents:
   a. Licensed Mental Health Practitioner (LMHP);
   b. Provisionally Licensed Mental Health Practitioner (PLMHP);
   c. Specially Licensed Psychologist or Psychology Resident;
   d. Qualified Registered Nurse - a registered nurse (R.N., R.N. with Bachelors, Masters, or Ph.D. or certification as a psychiatric clinical specialist or nurse practitioner by the American Nurses Association);
   e. Qualified Mental Health Professional Masters or Masters Equivalent - a holder of a masters degree in a closely related field that is applicable to the bio/psycho/social sciences or to treatment for mental health or substance abuse; or a Ph.D. candidate who has bypassed the masters degree but has sufficient hours to satisfy a masters degree requirement; or a holder of a master's degree who is actively pursuing licensure as a mental health practitioner as allowed by the Nebraska Department of Health and Human Services, Division of Public Health; and
   f. Licensed Alcohol/Drug Counselor - a person licensed by the Nebraska Department of Health and Human Services Division of Public Health or by the appropriate agency in the state where the service is performed.

4. For NMAP purposes, the following qualified staff may provide mental health home health and personal care services or child supervision/care:
   a. Qualified Child/Adolescent Service Professional (mental health home health care provider) - a holder of a baccalaureate degree in psychology, social work, child development or a related field from an accredited university or college; or a holder of a baccalaureate degree in another field who has advanced training in one or more of the above disciplines or has post high school coursework in psychology, social work, sociology, and/or other related fields and has demonstrated skills and competencies to work with seriously emotionally disturbed children and adolescents as determined by the provider. A minimum of three years of experience in direct child/adolescent services or mental health services is required, along with extensive knowledge of and ongoing training in children/adolescent mental health needs.
   b. Qualified Mental Health Technician (mental health personal care aide) - a person at least 19 years of age who has completed a Department-approved training program.
5. Any NMAP provider who is licensed by the Nebraska Department of Health and Human Services, Division of Public Health and has a substantiated disciplinary action filed against that license that limits the provision of services will not be allowed to provide NMAP services. If a provider is licensed by another state, substantiated discipline action filed against that license that limits the provision of services will be cause for termination as an NMAP provider.

32-001.05 Clinical Records: Each provider of mental health and substance abuse services for children and adolescents shall maintain a clinical record for each Medicaid-eligible client that fully discloses the extent of the treatment services rendered. The clinical record must contain documentation sufficient to justify NMAP participation, and must allow an individual not familiar with the client to evaluate the course of treatment. The absence of appropriate, legible, and complete records may result in recoupment of previous payments for services.

Clinical records must be arranged in a logical order such that the clinical information can be easily reviewed, audited, and copied. Each provider shall maintain accurate, complete, and timely records and shall always adhere to procedures that ensure the confidentiality of clinical data.

Clinical records shall include, at a minimum, the following:

1. Statement of medical necessity;
2. Documentation of the HEALTH CHECK (EPSDT) Screen or interperiodic screen;
3. Copy of the pre-treatment assessment;
4. Treatment plans - initial, reviews, and revisions;
5. Progress notes;
6. Discharge planning; and
7. The client's Medicaid I.D. number.

Clinical records shall be maintained for a minimum of seven years. Clinical records must be written legibly or typed. If three separate individuals cannot understand the information written in a record because of handwriting that is difficult to read, the program shall provide a readable format.

Providers of mental health/substance abuse services to child and adolescents must comply with Department requests to review clinical records. This review may be of photocopies or on-site at the discretion of Department staff.

32-001.06 Active Treatment: Active treatment is provided under an individualized treatment plan developed by the supervising practitioner and clinical professional(s) as required for each level of care. The plan must be based on a thorough evaluation of the client's restorative needs and potentialities for a primary mental health or substance abuse diagnosis. An isolated service, such as a single session with a licensed mental health professional or a routine laboratory test, not furnished under a planned program of therapy or diagnosis, is not active treatment even though the service was therapeutic or diagnostic in nature.

The services must be reasonably expected to improve the client's bio-psycho-social condition or to determine a mental health and substance abuse diagnosis in a timely manner. The treatment must, at a minimum, be designed to reduce or control the client's mental health and substance abuse symptoms to facilitate the client's movement to a less restrictive environment within a reasonable period of time as determined by the pre-treatment assessment.

Methods of measuring the client's progress must be part of the treatment plan.

The kinds of services that meet this requirement include individual and group psychotherapy, family therapy, drug therapy, specialized treatment programs, substance abuse counseling and adjunctive therapies, such as occupational therapy, recreational therapy, physical therapy, and speech therapy. These services must be face-to-face to meet the active treatment criteria. The adjunctive therapeutic services must be expected to improve the client's condition. If the only activities prescribed for the client are primarily diversional in nature, (i.e., to provide some social, education, or recreational outlet for the patient), NMAP does not consider the services as treatment to improve the client's condition.

The administration of a drug or drugs does not necessarily constitute active treatment (i.e., the use of mild tranquilizers, sedatives, antidepressants, or antipsychotics solely to alleviate anxiety, insomnia, depression, or psychotic symptoms).

The services of a licensed practitioner must be supervised, directed, and evaluated by a supervising practitioner. The services of other qualified professionals or clinical staff (i.e., occupational therapists, physical therapists, speech therapists, treatment foster care (TFC) parents, etc.) must be prescribed by the supervising practitioner to meet the specific mental health/substance abuse needs of the client.

Active treatment services will be reimbursed and evaluated by the level of care needed, not solely the professional level of the staff providing the care.

Treatment provided to the client must be documented in the clinical record in a manner and with a frequency to provide a full picture of the therapies provided, as well as an assessment of the client's reaction to the treatment interventions.

32-001.07 Treatment Planning: The treatment plan is a comprehensive plan of care formulated by the clinical staff under the direction of a supervising practitioner and is based on the individual needs of the client. The treatment plan validates the necessity and appropriateness of services and outlines the service delivery needed to meet the identified needs, reduce problem behaviors, and improve overall functioning.

The treatment plan must be based upon an assessment of the client's problems and needs in the areas of emotional, behavioral, and skills development. The treatment plan must be individualized to the client and must include the specific problems, behaviors, or skills to be addressed; clear and realistic goals and objectives; services, strategies, and methods of intervention to be implemented; criteria for achievement; target dates; methods for evaluating the client's progress; and the responsible professional.

The goals and objectives documented on the treatment plan must reflect the recommendations included in the Pre-treatment Assessment and the integration of input from the supervising practitioner and the therapist. The treatment interventions provided must reflect these recommendations, goals, and objectives. Evaluation of the treatment plan by the therapist and the supervising practitioner should reflect the client's response to the treatment interventions based on the recommendations, goals and objectives.

The provider must document their attempts to involve the family in treatment plan development and treatment plan reviews. A variety of communication means should be considered. These may include, but should not be limited to, including the family via conference telephone calls, using registered letters to notify the family of meetings, and scheduling meetings in the evening and on weekends.

Providers must be available to schedule meetings and sessions in a flexible manner to accommodate and work with a family's schedule. This includes the ability to schedule sessions at a variety of times including weekends or evenings.

A treatment plan must be developed for every client within the time frames specified for each type of service and must be placed in the client's clinical record. If a treatment plan is not developed within the specified time frames, services rendered may not be reimbursable through NMAP.

The treatment plan must be reviewed and updated by the treatment team according to the client's level of functioning. Minimum time frames for treatment plan reviews are dependent on the type of service. Refer to each individual service description for the review requirements. The purpose of this review is to ensure that services and treatment goals continue to be appropriate to the client's current needs, and to assess the client's progress and continued need for mental health services. The supervising practitioner and clinical staff members shall sign and date the treatment plan at each treatment plan review.

If the client is receiving services from more than one mental health and substance abuse provider, these agencies must coordinate their services and develop one overall treatment plan for the client or family. This treatment plan is used by all providers working with the client or family.

32-001.07A Transition and Discharge Planning: Throughout a client's care and whenever a client is transferred from one level of care to another, transition and discharge planning must occur and be documented, beginning at the time of admission. The focus of transition and discharge planning is to facilitate a timely transition out of the treatment system or to a less restrictive level of care. Treatment providers are responsible for transition and discharge planning.

Providers must meet the following standards regarding transition and discharge planning:

1. Transition and discharge planning must begin on admission;
2. Discharge planning must be based on the treatment plan to achieve the client's discharge from the current treatment status and transition into a different level of care;
3. Transition and discharge planning must address the client's need for ongoing treatment to maintain treatment gains and to continue normal physical and mental development following discharge;
4. Discharge planning must include identification of and clear transition into developmentally appropriate services needed following discharge;
5. Treatment providers must make or facilitate referrals and applications to the next level of care or treatment provider.
6. The current provider must arrange for prompt transfer of appropriate records and information to ensure continuity of care during transition into the next level of care;
7. A written transition and discharge summary must be provided as part of the clinical record; and
8. The parents/guardians and case manager(if the client is a state ward) must be included in all phases of transition and discharge planning. This participation must be clearly documented in the client's clinical record.

32-001.08 Place of Service: The place of service is dependent on the type of service. Refer to each individual service description for the eligible places of service.

32-001.09 Services Provided to State Wards: If the client is a state ward, the Department case manager must be directly involved in all phases of treatment planning, active treatment, and transition/discharge planning and must receive monthly progress reports regarding the client's therapy. The case manager must be contacted for consent to treat and informed consent for treatment or medication initiation changes. This does not preclude the provider's responsibility to work with the client's family. The monthly report must address, at a minimum, current treatment goals, progress on those treatment goals, and therapy goals for the following month. Payment for services may be denied if appropriate reports are not provided to the Department case manager in a timely manner.

32-001.10 Inspection of Care (IOC): The Department's inspection of care team, consisting of a licensed practitioner of the healing arts who is able to diagnose and treat major mental illness within his/her scope of practice and who is knowledgeable about mental health and substance abuse services, and other appropriate personnel as necessary, may conduct inspection of care reviews for services covered under EPSDT as mental health and substance abuse services for children and adolescents. Copies of the IOC report will be made available to the licensing agency for the facility. The IOC team will make referrals to any current accreditation agency or other licensing agencies, such as the Department of Health and Human Services, Division of Public Health. The Inspection of Care will be performed under the Institutions for Mental Disease regulations at 42 CFR 456.600-.614.

32-001.11 Inspections of Care: Under 42 CFR 456, Subpart I, the Department's inspection of care team shall periodically inspect the care and services provided to clients in each type of services under the following policies and procedures.

32-001.11A Inspection of Care Team: The inspection of care team must meet the following requirements:

1. The inspection of care team must have a licensed practitioner of the healing arts who is able to diagnose and treat major mental illness within his/her scope of practice who is knowledgeable about mental health and substance abuse services and other appropriate personnel;
2. The team must be supervised by a licensed practitioner of the healing arts who is able to diagnose and treat major mental illness within his/her scope of practice, but coordination of the team's activities remains the responsibility of the Division of Medicaid and Long-Term Care;
3. A member of the inspection of care team may not have a financial interest in any institution of the same type in which s/he is reviewing care but may have a financial interest in other facilities or institutions. A member of the inspection of care team may not review care in an institution where s/he is employed, but may review care in any other facility or institution.
4. A licensed practitioner member of the team may not inspect the care of a client for whom s/he is the attending licensed practitioner.
5. A primary consumer, secondary consumer, or family member may be included in the inspection of care team at the discretion of the Department.
6. There must be a sufficient number of teams so located within the state that on-site inspections can be made at appropriate intervals in each facility caring for clients.

32-001.11B Frequency of Inspections: The inspection of care team and the Department shall determine, based on the quality of care and services being provided in a facility and the condition of clients in the facility, at what intervals inspections will be made.

32-001.11C Notification Before Inspection: No facility may be notified of the time of inspection more than 48 working hours before the scheduled arrival of the inspection of care team. The inspection of care team may inspect a facility with no prior notice at their discretion.

32-001.11D Components of the Inspection of Care: The team's inspection must include -

1. Personal contact with and observation of each client;
2. Review of each client's medical record; and
3. Review of the facility's policies as they pertain to direct patient care for each client being reviewed in the inspection of care, in accordance with 42 CFR 456.611(b)(1).

32-001.11E Determinations by the Team: The inspection of care team shall determine in its inspection whether -

1. The services available in the facility are adequate to -
   a. Meet the health needs of each client; and
   b. Promote his/her maximum physical, mental, and psychosocial functioning;
2. It is necessary and desirable for the client to remain in the facility;
3. It is feasible to meet the client's health needs through alternative institutional or noninstitutional services; and
4. Each client age 20 or younger in a psychiatric facility is receiving active treatment as defined in 42 CFR 441.154 and 471 NAC 32-001.06.

If, after an inspection of care is complete, the inspection of care team determines that a follow-up visit is required to ensure adequate care, a follow-up visit may be initiated by the team. This will be determined by the inspection of care team and will be noted in the inspection of care report.

32-001.11F Basis for Determinations: Under 42 CFR 456.610, in making the determinations by the team on the adequacy of services and other related matters, the team will determine what items will be considered in the review. This will include, but is not limited to, items such as whether -

1. The medical evaluation, family assessments, social and psychological evaluations, and the plan of care are complete and current; the plan of care, and when required, the plan of rehabilitation are followed; and all recommended services, are provided and properly recorded;
2. A program physician reviews prescribed medications at least every 30 days;
3. Tests or observations of each client indicated by his/her medication regimen are made at appropriate times and properly recorded;
4. Physician, licensed psychologist, and other professional progress notes are made as required and appear to be consistent with the observed condition of the client;
5. The client receives adequate services, based on such observations as -
   a. Cleanliness;
   b. General physical condition and grooming;
   c. Mental status;
   d. Apparent maintenance of maximum physical, mental, and psychosocial function;
6. The client receives adequate rehabilitative services, as evidenced by -
   a. A planned program of activities to prevent regression; and
   b. Progress toward meeting objectives of the plan of care;
7. The client needs any service that is not furnished through the facility or through arrangements with others;
8. The client needs a continued placement in the facility or there is an appropriate plan to transfer the client to an alternate method of care, which is the least restrictive, most appropriate environment that will still meet the client's needs;
9. Direct involvement of families and/or legal guardians, in all phases of treatment, including the Department for Department wards; and
10. The facility's standards of care and policy and procedure meets the requirements for adequacy, appropriateness, and quality of services as they relate to individual clients, as required by 42 CFR 456.611(b)(1).

32-001.11G Reports on Inspections: The inspection of care team shall submit a report to the Director of the Division of Medicaid and Long-Term Care on each inspection. The report must contain the observations, conclusions, and recommendations of the team concerning -

1. The adequacy, appropriateness, and quality of all services provided in the facility or through other arrangements, including physician services to clients; and
2. Specific findings about individual clients in the facility.

The report must include the dates of the inspection and the names and qualifications of the team members. The report must not contain the names of clients; codes must be used. The facility will receive a copy of the codes.

32-001.11H Copies of Reports: Under 42 CFR 456.612, the Department shall send a copy of each inspection report to -

1. The facility inspected;
2. The facility's utilization review committee;
3. The Nebraska Department of Health and Human Services, Division of Public Health;
4. The Nebraska Department of Health and Human Services, Division of Behavioral Health; and
5. Other licensing agencies or accrediting bodies at the discretion of the review team.

If abuse or neglect is suspected, Medicaid staff shall make a referral to the appropriate investigative body.

32-001.11J Facility Response: Within 15 days following the receipt of the inspection of care team's report, the facility shall respond to the Inspection of Care Team in writing, and shall include the following information in the response:

1. A reply to any inaccuracies in the report. Written documentation to substantiate the inaccuracies must be sent with the reply. The Department will take appropriate action to note this in a follow-up response to the facility;
2. A complete plan of correction for all identified Findings and Recommendations;
3. Changes in level of care or discharge;
4. Action to individual client recommendations; and
5. Projected dates of completion on each of the above.

If additional time is needed, the facility may request an extension.

At the facility's request, copies of the facility's response will be sent to all parties who received a copy of the inspection report in 471 NAC 32-001.11H.

A return site visit may occur after the written response is received to determine if changes have completely addressed the review team's concerns from the IOC report.

The Department will take appropriate action based on confirmed documentation on inaccuracies.

32-001.11K Department Action on Reports: The Department will take corrective action as needed based on the report and recommendations of the team submitted under this subpart.

32-001.11L Appeals: See 471 NAC 2-003 ff. and 465 NAC 2-001.02 ff. and 2-006 ff.

32-001.11M Failure to Respond: If the facility fails to submit a timely and/or appropriate response, the Department may take administrative sanctions (see 471 NAC 2-002 ff.) or may suspend NMAP payment for an individual client or the entire payment to the facility.

32-001.12 Payment for Specialized Mental Health and Substance Abuse Treatment Services: Payment for specialized treatment services will be based upon rate setting by the Department.

These regulations define a system of payment for all specialized mental health and substance abuse treatment programs (Day Treatment, Treatment Crisis Intervention, Treatment Foster Care, Treatment Group Home, and Residential Treatment Center) participating in NMAP.

Payment rates for specialized treatment services for children and adolescents will be on a unit basis. Rates are set annually, for the period July 1 through June 30. Rates are set prospectively for this period, and are not adjusted during the rate period.

Providers are required to report their costs for each specialized mental health and substance abuse treatment service on an annual basis. Providers may choose any fiscal year end that they desire. Providers desiring to enter the program who have not previously reported their costs, or that are newly operated, are to submit a budgeted cost report, estimating their anticipated annual costs.

Providers shall submit cost and statistical data on Form FA-20 for each specialized mental health and substance abuse treatment service. The provider shall submit one original Form FA-20 to the Department within 90 days of the close of fiscal year, or change in ownership or management. One 15-day extension may be granted under extenuating circumstances if requested in writing prior to the date. Providers shall compile data based on generally accepted accounting principles and the accrual method of accounting based on the provider's fiscal year. Financial and statistical records for the period covered by the cost report must be accurate and sufficiently detailed to substantiate the data reported. All records must be readily available upon request by the Department for verification. If the provider fails to file a cost report as due, the Department will suspend payment. At the time the suspension is imposed, the Department will send a letter informing the provider that no further payment will be made until a proper cost report is filed.

In setting payment rates, the Department will consider those costs which are reasonable and necessary for the active treatment of the clients being served. Such costs will include those necessary for licensure and accreditation, meeting all staffing standards for participation, meeting all service standards for participation, meeting all requirements for active treatment, maintaining medical records, conducting utilization review, meeting inspection of care and discharge planning.

The Department does not guarantee that all costs will be reimbursed. The Form FA-20 cost reporting document is used by the Department only as a guide in the rate setting process. Actual costs incurred by the providers may not be entirely reimbursed.

32-001.12A Payment Rates for Specialized Treatment Services Provided by State-Operated Facilities: Specialized treatment services operated by the State of Nebraska will be reimbursed for all reasonable and necessary costs of operation, excluding educational services. State-operated centers will receive an interim payment rate, with an adjustment to actual costs following the cost reporting period.

32-001.12B Unallowable Costs: The following costs are not allowable:

1. Provisions for income tax;
2. Fees paid board of directors;
3. Non-working officers' salaries;
4. Promotion expense, except for promotion and advertising as allowed in HIM-15. Yellow Page display advertising is not allowable; one Yellow Page informational listing is allowable;
5. Travel and entertainment, other than for professional meetings and direct operations of the treatment program. This may include costs of motor homes, boats, and other recreational vehicles, including operation and maintenance expenses; real property used as vacation facilities; etc.;
6. Donations;
7. Expenses of non-related facilities and operations included in expense;
8. Insurance and/or annuity premiums on the life of officer or owner;
9. Bad debts, charity, and courtesy allowances;
10. Cost and portions of costs which are determined by the Department not to be reasonably related to the efficient production of service because of either the nature or amount of the particular expenditure;
11. Education costs as defined in 471 NAC 32-004.01C, 471 NAC 32-006.05J, and 471 NAC 32-007.05J;
12. Services provided by the client's physicians or dentists, drugs, laboratory services, radiology services, or services provided by similar independent licensed providers, except services provided by state operated facilities. These exclusions are paid separately;
13. Return on equity;
14. Costs for services which occurred in a prior or subsequent fiscal year are unallowable;
15. Expenses for equipment, facilities, and programs (e.g., recreation, trips) provided to clients which are determined by the Department not to be reasonably related to the efficient production of service because of either the nature or amount of the particular service;
16. Costs of amusements, social activities, and related expenses for employees and governing body members are unallowable, except when part of an authorized client treatment program;
17. Costs of alcoholic beverages are unallowable;
18. Costs resulting from violations of, or failure to comply with federal, state, and local laws and regulations are unallowable;
19. Costs relating to lobbying or attempts to influence/promote legislative action by local, state, or federal government are unallowable; and
20. Costs of lawsuits or other legal or court proceedings against the Department, or its employees, or State of Nebraska are unallowable.

32-001.12C Suspension or Termination of Enrollment: The Department does not make payment for care provided after 30 days following the date of expiration or termination of the provider's enrollment for reimbursement under Title XIX. The Department does not make payment for care provided to individuals who were admitted after the date of expiration or termination of the provider's enrollment or certificate to operate under Title XIX.

32-001.12D Appeal Process: Final administrative decision or inaction in the rate setting process is subject to administrative appeal. The provider may request an appeal in writing from the Director for a hearing within 90 days of the decision or inaction. Regulations for appeals and fair hearings are contained in 465 NAC 2-001.02 and 2-006 ff.

32-001.12E Administrative Finality: An administrative decision or inaction in the allowable cost determination process, which is otherwise final, may be reopened by the Department within three years of the date of notice of the decision or inaction.

"Reopening" is an action taken by the Director to re-examine or question the correctness of a determination or decision which is otherwise final. The Director is the sole authority for deciding whether to reopen an administrative decision or inaction. The action may be taken -

1. On the initiative of the Department within the three-year period;
2. In response to a written request of a provider or other entity within the three-year period. Whether the Director will reopen a determination, which is otherwise final, depends on whether new and material evidence has been submitted, a clear and obvious error has been made, or the determination is found to be inconsistent with any law, regulations and rulings, or general instructions; or
3. Any time fraud or abuse is suspected.

A provider has no right to appeal a finding by the Director that a reopening or correction of a determination or decision is not warranted.

32-001.13 Record Retention: The provider shall retain financial records, supporting documents, statistical records, and all other pertinent records related to the cost report for a minimum of five years after the end of the report period. The Department shall retain all cost reports for at least five years after receipt from the provider.

32-001.14 Billing Requirements: For Mental Health and Substance Abuse Services, providers shall follow these requirements -

1. Providers of mental health and substance abuse treatment services in a non-hospital setting shall submit claims for services on an appropriately completed Form CMS-1500 (see 471-000-64) or the standard electronic Health Care Claim: Professional transaction (ASC X12N 837).

   Payment for approved mental health treatment and substance abuse services is made to the facility or provider named on the provider agreement.

2. Providers of mental health and substance abuse treatment services from a hospital shall submit claims for services on an appropriately completed Form CMS-1450 or the standard electronic Health Care Claim: Institutional transaction (ASC X12N 837).

   Payment for approved mental health treatment substance abuse services is made to the provider named on the provider agreement.

32-001.14A Procedure Codes: Providers shall use HCPCS/CPT codes when submitting claims to the Department for Medicaid services. HCPCS/CPT procedure codes used by NMAP are listed in the Nebraska Medicaid Practitioner Fee Schedule (see 471-000-532).

32-001.15 General Requirements and Definitions for Mental Health and Substance Services: The requirements of this section apply to all mental health and substance abuse services for individuals age 20 and younger provided under the Nebraska Medical Assistance Program (NMAP).

32-001.15A Philosophy of Care: The Department's philosophy is that all care provided to clients must be provided at the least restrictive and most appropriate level of care. More restrictive levels of care will be used only when all other resources have been explored and deemed to be inappropriate.

32-001.15B Non-Discrimination: The Department believes that each person, regardless of race, color, sex, age, religion, national origin, disability, sexual orientation, or marital status possesses inherent worth and value. The Department expects services to be provided in a way that shows respect and support for such diversity. Providers must be aware of the issues which may arise and ask for consultation or make referrals as needed.

32-001.15C Family of Origin Component: Care must address family of origin concerns and, whenever possible, involve the family in treatment planning, therapy, and transition/discharge planning. Family may include biological, step, foster, or adoptive parents; siblings or half siblings; and extended family members, as appropriate. Family involvement, or lack thereof, must be documented in the clinical record.

Providers must encourage family members to be involved in the assessment of the client, the development of the treatment plan, and all aspects of the client's treatment unless prohibited by the client, through legal action, or because of federal confidentiality laws.

Providers must be available to schedule meetings and sessions in a flexible manner to accommodate and work with a family's schedule. This includes the ability to schedule sessions at a variety of times including weekends or evenings.

The provider must document their attempts to involve the family in treatment plan development and treatment plan reviews. A variety of communication means should be considered. These may include, but should not be limited to, including the family via conference telephone calls, using registered letters to notify the family of meetings, and scheduling meetings in the evening and on weekends.

32-001.15D Community-Based Care: Care must be community-based and, when appropriate, must involve a representative from the client's community support system other than the Department case manager. This may include areas such as education, social services, law enforcement, religion, medical, and other mental health or substance abuse professionals. Community involvement must be documented in the clinical record. This documentation must include any lack of cooperation or resistance from the community support system.

32-001.15E Developmentally Appropriate Care: Care must address the client's biological, psychological, and social development. Therapeutic interventions must be congruent with the findings of the developmental level of the client based on comprehensive psychiatric and psychological assessments.

32-001.15F Coordinated Services: If a client is receiving services from more than one mental health and substance abuse provider, there must be documented coordination of all services. Coordination of services is required as part of the overall treatment plan and is not billable as a separate service. The services provided must be identified on one overall treatment for the client or family.

32-001.15G Out-of-State Services: See 471 NAC 1-000 ff. In addition, out-of-state providers of Chapter 32 services must have specific plan of how they will meet the family and community requirements and approved by the Department to be a provider of NMAP services.

32-001.15H Quality Assurance and Utilization Review: All providers participating in NMAP have agreed to provide services under the requirements of 471 NAC 2-001.03, Provider Agreements. If there is any question or concern about the quality of service being provided by an enrolled provider, the Department may perform quality assurance and utilization review activities, such as on-site visits, to verify the quality of service. If the provider or the services do not meet the standards of this chapter, the provider may be subject to administrative sanctions under 471 NAC 2-002 ff. or denial of provider agreement for good cause under 471 NAC 2-001.02A. The Department may request a refund for all services not meeting Chapter 32 requirements.

If the clients are in immediate jeopardy, the sanctions may be imposed under 471 NAC 2-002.05 without a hearing.

32-001.15J Cultural Competence: Providers of mental health and substance abuse services to children and adolescents must be culturally competent. This includes awareness, acceptance, and respect of differences and continuing self-assessment regarding culture. Cultural competence also includes careful attention to the dynamics of differences and how they affect interactions, assumptions, and the delivery of services. Providers also demonstrate cultural competence through continuous expansion of cultural knowledge and resources through training, readings, etc., and by providing a variety of adaptations to service models in order to meet the needs of different cultural populations.

Culturally competent providers hire unbiased employees, seek advice and consultation from the minority community, and actively decide whether or not they are capable of providing services to clients from other cultures. They provide support for staff to become comfortable working in cross-cultural situations and understand the interplay between policy and practice and are committed to policies that enhance services to diverse clientele.

32-001.15K Service Definitions: The following definitions of service apply within this chapter:

Individual Psychotherapy: A therapeutic one-to-one encounter between the client and a mental health or substance abuse professional acting within his/her scope of practice for an acceptable primary diagnosis. (No additional reimbursement is made for medication checks performed by a physician in the course of individual psychotherapy.)

Individual Substance Abuse Counseling: The utilization of a licensed alcohol and drug counselor's special skills and knowledge in a one-to-one session for the purpose of assisting the client in achieving treatment objectives.

Group Psychotherapy: A therapeutic encounter between the client and a mental health or substance abuse professional acting within his/her scope of practice in the context of a group setting of at least three and not more than twelve. Group psychotherapy must provide active treatment for a primary diagnosis. NMAP does not cover groups that are only supportive or educational in nature, or the services of a co-therapist.

Group Substance Abuse Counseling: An encounter between a client and a licensed alcohol and drug counselor using special skills and knowledge in a group setting of 3-12 persons for the purposes of assisting clients in achieving treatment objectives. Group substance abuse counseling must provide active treatment. NMAP does not cover groups that are only supportive or educational in nature, or the services of a co-therapist.

Family Psychotherapy: A therapeutic encounter between the client (identified patient), the nuclear and/or extended family, and a mental health or substance abuse professional acting within his/her scope of practice. These services must focus on the family as a system and include a comprehensive family assessment. The specific objective of treatment must be to alter the family system to increase the functional level of the identified patient. This therapy must be provided with the appropriate family members and the identified patient. The client need not be involved in every family session when working on parental issues, but the focus of the services must be on systems within the family unit. Therapists of families with more than one mental health/substance abuse provider must communicate with and coordinate services with any other mental health/substance abuse provider for the family or individual family members. Coordination of services is required as part of the overall treatment plan and is not billable as a separate service. Duplicate or co-therapist services will not be reimbursed. The client must be eligible for NMAP and have an acceptable primary psychiatric diagnosis.

Services of Psychiatric Resident Physicians: Psychiatric resident physicians may provide psychotherapy services and medication checks when these services are directly supervised by the attending psychiatrist. The resident's supervising psychiatrist shall sign the Department approved treatment planning document for services provided by the resident physician. The resident physician may not supervise services of physician extenders or clinical staff professionals.

Observation Room Services (23:59): When appropriate for brief crisis stabilization, outpatient hospital observation up to 23 hours 59 minutes in an emergency room or acute hospital may be used. An outpatient is defined as a person who has not been admitted as an inpatient but is registered on the hospital records as an outpatient and receives services. NMAP covers observation room services under the following conditions:

1. Since this service has the potential to become an inpatient hospitalization, the claim will be reviewed for the standards of care for inpatient services in 471 NAC 32-008 ff.;
2. If a patient receives 24 or more hours of continuous outpatient care, that patient is defined as an inpatient regardless of the hour of admission, whether s/he used a bed, and whether s/he remained in the hospital past midnight or the census-taking hour;

3. When the patient stays 24 hours, all inpatient prior-authorization requirements noted in 471 NAC 32-008 and 32-009 apply; and
4. The services must be billed as an outpatient hospital mental health or substance abuse service on Form CMS-1450. The assessment treatment plan, and all clinical records and reports are kept in the client's file.

Conferences with Family or Other Responsible Persons Advising Them on How to Assist the Client: A consultation between a mental health or substance abuse professional acting within his/her scope of practice and family or other responsible persons. The service must be related to current treatment issues based on the client's primary diagnosis. The service must have a direct effect on the treatment of the client. The service must require the expertise of the professional. Conferences may include the client's Department case manager, school staff members, probation officers, etc. This does not include communications related to scheduling appointments, transportation problems, or case management functions. Note: NMAP does not cover staff conferences that are supervisory or administrative in nature. Conference time must be billed according to the Nebraska Medicaid Practitioner Fee Schedule, using the appropriate procedure code. A progress note of the service must be attached to the Department approved treatment planning document to document the clinical necessity component of the conference.

32-002 Outpatient Mental Health and Substance Abuse Treatment Services

32-002.01 Covered Outpatient Mental Health and Substance Abuse Treatment Services: Outpatient mental health and substance abuse services are available to clients age 20 or younger when the client has participated in a HEALTH CHECK (EPSDT) screen, the treatment is clinically necessary, and the need for care at this level has been identified on the pre-treatment assessment. Outpatient mental health and substance abuse services must be family centered, community based, culturally competent, and developmentally appropriate. Outpatient mental health and substance abuse services include:

1. Evaluation by a supervising practitioner;
2. Psychiatric evaluation;
3. Psychological evaluation;
4. Psychological testing;
5. Individual Psychotherapy;
6. Individual Substance Abuse Counseling;
7. Group Psychotherapy (a group overview must be approved by Medicaid prior to billing for this service);
8. Group Substance Abuse Counseling (a group overview must be approved by Medicaid prior to billing for this service);
9. Family Psychotherapy Services;
10. Family Substance Abuse Counseling;
11. Family Assessment;
12. Conferences with family or other responsible persons advising them on how to assist the client;
13. Mileage for Home-Based Family Therapy or Home-Based Family Counseling Services;
14. MHSA Community Treatment Aides;
15. Intensive Outpatient Services and
16. Medication Checks (by a physician or physician extender only).

Outpatient mental health and substance abuse services must meet all of the requirements of 471 NAC 32-001.

32-002.02 Mental Health and Substance Abuse Services Staffing Standards: The following clinical staff may provide services within their scope of practice and must meet the requirements as defined in 471 NAC 32-001.04 -

1. Licensed practitioners of the healing arts who are able to diagnose and treat major mental illness within their scope of practice;
2. Psychiatrically Trained Physician Extenders;
3. Licensed Independent Mental Health Practitioners;
4. Licensed Mental Health Practitioner;
5. Provisionally Licensed Mental Health Practitioners;
6. Licensed Alcohol and Drug Counselors; and
7. Mental Health Technicians.

The outpatient treatment interventions provided by licensed practitioners must be directly supervised according to the following standards in addition to the standards listed in 471 NAC 32-001.02B Definition and Practice of Supervision:

1. The supervising practitioner must prescribe and order all treatment interventions based on the biopsychosocial assessment completed by the therapist and the supervising practitioner's Initial Diagnostic Interview.
2. The supervising practitioner and therapist or counselor must have a supervisory contact (either in person or by phone) every 30 days, or more often if necessary, to review the treatment of the client and the treatment plan. This supervisory contact and related changes in the treatment program should be reflected on the treatment planning document. There is no additional payment available to the supervising practitioner or therapist for this supervisory contact.

32-002.02A Location of Services: Outpatient mental health and substance abuse services by qualified staff may be provided in -

1. A licensed and certified hospital which provides psychiatric or substance abuse services and which -
   a. Is maintained for the care and treatment of patients with primary mental health and/or substance disorders;
   b. Is licensed or formally approved as a hospital by the Nebraska Department of Health and Human Services, Division of Public Health or if the hospital is located in another state, the officially designated authority for standard - setting in that state;
   c. Is accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) or by the AOA;
   d. Has licensed and certified psychiatric and/or substance abuse beds;
   e. Meets the requirements for participation in Medicare for psychiatric hospitals; and
   f. Has in effect a utilization review plan applicable to all Medicaid clients;

2. A licensed and certified hospital which provides acute medical services and which -
   a. Is maintained for the care and treatment of patients with acute medical disorders;
   b. Is licensed or formally approved as a hospital by the Nebraska Department of Health and Human Services, Division of Public Health, or if the hospital is located in another state, the officially designated authority for standard - setting in that state;
   c. Is accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) or by the AOA;
   d. Meets the requirements for participation in Medicare for acute medical hospitals; and
   e. Has in effect a utilization review plan applicable to all Medicaid clients;
3. The private office of a licensed practitioner of the healing arts who is able to diagnose and treat major mental illness within his/her scope of practice;
4. The private office of a clinical staff person operating within the licensure guidelines of the Nebraska Department of Health and Human Services, Division of Public Health;
5. Rural Health Clinics and Federally Qualified Health Centers;
6. The client's home;
7. The client's school;
8. Nursing facilities and ICF/MR's; or
9. Other locations appropriate to the provision of service.

Services are not covered when provided in any other location.

32-002.03 Provider Agreement: A provider of outpatient mental health or substance abuse services shall complete a provider agreement, and submit the form to the Department for approval with any other information requested by the Department (see 471 NAC 32-001.03).

If an agency will be providing MHSA Community Treatment Aide services, the following information must be submitted with the provider agreement:

1. A complete listing of the services provided by the agency;
2. An overview of the criteria used in ordering MHSA Community Treatment Aide services.
3. A complete list of the MHSA Community Treatment Aide services staff and a current resume for each staff member;
4. The staff training and development program used by the applying agency; and
5. A description of how the MHSA Community Treatment Aide staff will interact with the agency's professional staff and supervising practitioner.

32-002.04 Coverage Criteria for Outpatient Mental Health and Substance Abuse Services: The Nebraska Medical Assistance Program covers outpatient mental health and substance abuse services listed in 471 NAC 32-002.01 when the services are clinically necessary and provide active treatment as defined in 471 NAC 32-001.06.

Clinical necessity and active treatment for outpatient services is documented through the use of the treatment plan (471 NAC 32-002.06) which must be developed by the therapist and supervising practitioner, based on a thorough evaluation of the client's restorative needs and potentialities, for a primary diagnosis from the current Diagnostic and Statistics Manual published by the American Psychiatric Association excluding V-codes and developmental disorders.

32-002.04A Services Provided by Clinical Staff Professionals: Other than services of a Licensed Independent Mental Health practitioner, services provided by clinical staff (as defined in 471 NAC 32-001.04) must be prescribed and provided under the direction of a supervising practitioner. Supervision must meet the active treatment criteria in 471 NAC 32-001.06 and the definition and practice of supervision listed in 471 NAC 32-001.02B. The supervising practitioner must personally re-evaluate the client, through a face-to-face interview, annually or more often, if necessary.

32-002.04B Services Provided by Child/Adolescent Service Professionals and Mental Health Technicians: Services provided by these staff (as defined in 471 NAC 32-001.04) must be prescribed and provided under the direction of a supervising practitioner. This is included in reviewing the treatment plan every 90 days and re-evaluation of the client through a face-to-face interview annually, or more often as clinically necessary.

32-002.05 Pre-Treatment Assessment: Prior to the initiation of outpatient mental health and substance abuse services, a thorough assessment as defined in 471 NAC 32-001.01 Pre-Treatment Assessment, (biopsychosocial assessment, and initial diagnostic interview) shall be completed.

32-002.06 Treatment Plan: When treatment is initiated, the provider shall work with the client and family to complete the treatment plan (see 471 NAC 32-001.07, Treatment Planning). If the client is accepted for treatment, the treatment plan must be developed within two sessions of the Initial Diagnostic Interview by the supervising practitioner and must be based on the following:

1. The client must have sufficient need for active mental health or substance abuse treatment at the time the service provider accepts the client;
2. The treatment must be the best choice for expecting reasonable improvement in the client's mental health or substance abuse condition; and
3. The goals and objectives documented on the treatment plan must reflect the recommendations included in the Pre-treatment Assessment and the integration of input from the supervising practitioner and the therapist. The treatment interventions provided must reflect these recommendations, goals, and objectives. Evaluation of the treatment plan by the therapist and the supervising practitioner should reflect the client's response to the treatment interventions based on the recommendations, goals and objectives.

Providers must encourage family members to be involved in the assessment of the client, the development of the treatment plan, and all aspects of the client's treatment unless prohibited by the client, through legal action, or because of federal confidentiality laws.

Providers must be available to schedule meetings and sessions in a flexible manner to accommodate and work with a family's schedule. This includes the ability to schedule sessions at a variety of times including weekends or evenings.

The provider must document their attempts to involve the family in treatment plan development and treatment plan reviews. A variety of communication means should be considered. These may include, but should not be limited to, including the family via conference telephone calls, using registered letters to notify the family of meetings, and scheduling meetings in the evening and on weekends.

32-002.06A Treatment Plan Update: The treatment plan must be reviewed and updated every 90 days (or more frequently if clinically indicated). Changes in the treatment plan must be noted on the current treatment plan. The client's clinical record must include the supervising practitioner's comments about the client's response to treatment and changes in the treatment plan. The supervising practitioner must review and sign off on the updated treatment plan prior to its initiation.

For services provided under the direction of a supervising practitioner, the signature of the supervising practitioner indicates his/her agreement that the scheduled treatment interventions are appropriate.

32-002.07 Documentation in Client's Clinical Records: All documents submitted to NMAP must contain sufficient information for identification (i.e., client's name, dates of service, provider's name). In addition to the requirements of 471 NAC 32-001.05, Clinical Records, the client's record must also include -

1. The pre-treatment assessment;
2. The treatment plan (initial, updates, and current);
3. The client's diagnosis. A provisional or interim diagnosis must be established at the time the client is accepted for treatment. This diagnosis must be reviewed and revised as a part of the treatment plan;
4. A chronological record of all mental health or substance abuse services provided to the client, the date performed, the duration of the session, and the staff member who conducted the session;
5. A chronological account of all medications prescribed, the name, dosage, and frequency to be administered and client's response;
6. A comprehensive family assessment;
7. A clear record of family and community involvement;
8. Documentation verifying coordination with other therapists when more than one mental health/substance abuse provider is involved with the client/family; and
9. Transition/discharge planning.

32-002.08 Transition/Discharge Planning Services: Providers of outpatient mental health and substance abuse services shall meet the transition/discharge planning requirements noted in 471 NAC 32-001.07A.

32-002.09 Utilization Review: Payment for outpatient mental health and substance abuse services is based on adequate documentation of clinical necessity and active treatment. All outpatient claims received by the Department are subject to utilization review by the Department.

Additional documentation from the client's clinical record may be requested by the Department prior to considering authorization of payment when the treatment plan does not adequately document clinical necessity for active treatment.

32-002.10 Guidelines for Specific Services

32-002.10A Psychological Testing and Evaluation Services: Testing and evaluation services must reasonably be expected to contribute to the diagnosis and plan of care established for the individual client. Clinical necessity must be documented.

Testing and evaluation services must be performed or supervised by a licensed psychologist who is acting within his/her scope of practice as defined by the Nebraska Department of Health and Human Services, Division of Public Health or the appropriate authority in the state where the treatment occurs. Testing may also be conducted by a specially licensed psychologist or master's level psychologist who has been approved by the Department of Health and Human Services, Division of Public Health. Both of these staff members must be supervised by a licensed psychologist.

A copy of the testing results and summary must be kept in the client's record with the treatment plan when billing for testing. If the evaluation is court ordered, the provider shall note this on the treatment plan and document clinical need for the service.

32-002.10B Medication Checks: Medication checks may only be done when medically necessary. When a physician provides psychotherapy services, medication checks are considered a part of the psychotherapy service. The only professionals who may provide and request reimbursement for medication checks are physicians and physician extenders.

32-002.10C After-Care: After-care as defined by the American Psychiatric Association is a complex system of services including, but not limited to, psychotherapy, medication checks, and social, rehabilitative, and educational services required and necessary to deinstitutionalize the patient who has undergone extended hospital treatment and care. This service package does not meet the criteria of active treatment and is not covered, as a package, by the Nebraska Medical Assistance Program. Individually-identified services may be claimed under the appropriate procedure code and are subject to the active treatment standard.

32-002.10D Professional and Technical Components for Hospital Diagnostic and Therapeutic Services: For regulations regarding professional and technical components for diagnostic and therapeutic hospital services, the elimination of combined billing, and non-physician services and items provided to hospital patients, refer to 471 NAC 10-000.

32-002.10E Mileage

32-002.10E1 Mileage for Home-Based Family Psychotherapy and Family Substance Abuse Counseling : NMAP pays for the clinical staff's mileage to the client's home when family psychotherapy or family substance abuse counseling services are provided at the client's home under the following guidelines:

1. Only one professional per visit per family may claim mileage for payment. Payment for mileage is not made for a second professional or for supervision.
2. If family psychotherapy or family substance abuse counseling is provided to more than one family in the same area on the same day, the actual mileage driven may be claimed only once.
3. Payment for mileage will be made for the shortest distance possible between the family's home and the professional's office or base of operations.
4. Payment for mileage is approved only when services are actually provided. There is no mileage reimbursement for "no-shows."
5. If a professional chooses to provide services in an area away from his/her base of operations in a town or area where home-based services are already available, NMAP will not make payment for mileage from the providers base of operations to the town or area in which home-based services are already available.

32-002.10E2 Travel to the Home of Individuals with Special Needs: If a client has a handicapping physical condition that prevents them from traveling to a mental health or substance abuse clinic or office, the provider may request prior authorization to bill for mileage to the client's home. The following requirements must be met:

1. The provider shall request prior authorization before the initiation of services;
2. The treatment must meet the criteria for active treatment and medical necessity;
3. The client's handicapping physical condition prevents his/her travel to the mental health or substance abuse clinic or office; and
4. The client's home is more than thirty (30) miles from the clinic or office.

This information must be provided, in writing, to the Medicaid Central Office staff or their designee for consideration.

32-002.10F Conferences: NMAP will pay for conferences with family or other responsible persons advising them on how to assist the client when the service is reasonably expected to improve the client's condition. The need for the conference must be appropriately documented on the Department approved treatment planning document. Conferences may include the client's Department case manager, school staff members, probation officers, etc., and must require the expertise of the professional. Scheduling appointments and reporting client progress are not considered conferences and NMAP does not cover conferences that are supervisory in nature.

32-002.10G MHSA Community Treatment Aide Services, Levels I and II: NMAP covers mental health community treatment aide services when the services are clinically necessary, ordered by the supervising practitioner who is part of the client's primary mental health service providing agency documented on the client's treatment plan and in the clinical record, and the services are expected to help the client attain or retain their capacity for living in the least restrictive environment.

1. MHSA Community Treatment Aide Services, Level I -
   a. Are provided in the client's place of residence, school, or other appropriate location;
   b. Are mental health interventions provided by a skilled child/adolescent service professional; and
   c. Include, but are not limited to -
      (1) Rehabilitating the client's social skills and relationship skills;
      (2) Aiding the client's guardians in using appropriate discipline interventions;
      (3) Aiding the client in using appropriate coping skills to manage his/her behavior; or
      (4) Providing specific interventions under the direction of the supervising practitioner.
2. MHSA Community Treatment Aide Services, Level II -
   a. Are provided in the client's place of residence, school, or other appropriate location;
   b. Are medically-oriented tasks related to a client's physical care requirements provided by a mental health technician;
   c. Include, but are not limited to -
      (1) Supervision and rehabilitation of basic personal care and activities of daily living;
      (2) Assisting with bladder and/or bowel requirements if part of a protocol for enuresis or encopresis;
      (3) Assisting the client with oral medication that is ordinarily self-administered, when ordered by the client's physician;
      (4) Accompanying the client to clinics or physician office visits, or on other trips to obtain medical diagnosis or treatment when the client requires 1:1 supervision while traveling; or
      (5) Supervision of the client, participation in activities, or appropriate discipline of the client.

32-002.10H Intensive Outpatient Services: Providers may develop intensive outpatient services to meet the needs of clients. These services may be developed as a program for a particular population or for an individual client. These services must be approved by the Department's Medicaid staff and enrolled as outpatient services.

For the fee-for-service program, each particular service must be billed separately.

32-002.10J Family Assessment: NMAP covers family assessments used to identify the functional level of the family unit and the system changes that would influence this functional level. This includes interviews with the client and collateral parties.

32-002.11 Payment for Outpatient Mental Health and Substance Abuse Services

32-002.11A Payment for Outpatient Mental Health and Substance Abuse Services: Payment for outpatient mental health and substance abuse services is made according to the Nebraska Medicaid Practitioner Fee Schedule at 471-000-532. The NMAP pays for covered outpatient mental health and substance abuse services at the lower of -

1. The provider's submitted charge; or
2. The allowable amount for that procedure code in the Nebraska Medicaid Practitioner Fee Schedule for that date of service. The allowable amount is indicated in the fee schedule as -
   a. The unit value multiplied by the conversion factor;
   b. The maximum allowable dollar amount; or
   c. The reasonable charge for the procedure as determined by the Medicaid Division (indicated as "BR" - by report or "RNE" - rate not established - in the fee schedule).

32-002.11B Revisions of the Fee Schedule: The Department reserves the right to adjust the fee schedule to -

1. Comply with changes in state or federal requirements;
2. Comply with changes in national standard code sets, such as HCPCS and CPT;
3. Establish an initial allowable amount for a new procedure based on information that was not available when the fee schedule was established for the current year; and
4. Adjust the allowable amount when the Medicaid Division determines that the current allowable amount is -
   a. Not appropriate for the service provided; or
   b. Based on errors in data or calculation.

HCPCS/CPT codes used by NMAP are listed in the Medicaid Practitioner Fee Schedule at 471-000-532.

32-002.12 Billing Requirements: For outpatient mental health and substance abuse service providers, the following requirements must be met.

1. Community mental health and substance abuse programs providing outpatient services shall submit all claims for services on an appropriately completed Form CMS-1500 (see 471-000-64) or the standard electronic Health Care Claim: Practitioner transaction (ASC X12N 837).

   Payment for approved outpatient services provided by employees of a community mental health or substance abuse center is made to the facility.

2. Hospitals providing outpatient mental health services shall submit all claims for non-physician services on an appropriately completed Form CMS-1450 or the standard electronic Health Care Claim: Institutional transaction (ASC X12N 837).

   All physician services shall be submitted on an appropriately completed Form CMS-1500 or the standard electronic Health Care Claim: Professional transaction (ASC X12N 837).

   Payment for approved outpatient services provided by employees of a hospital is made to the provider as named on the provider agreement.

3. Independent providers of outpatient mental health and substance abuse services shall submit all claims for outpatient services provided on an appropriately completed Form CMS-1500 (see 471-000-64) or the standard Health Care Claim: Professional transaction (ASC X12N 837).

   Payment for approved outpatient services provided by an independent provider is made to the provider as identified on the provider agreement.

32-002.12A Documentation for Claims: For outpatient mental health and substance abuse services, unless otherwise instructed by Medicaid, the following documentation must be kept in the client's clinical record:

1. The pre-treatment and treatment plan when applicable, or an updated version of the treatment plan completed every six months;
2. For conferences, a copy of the clinical record for the conference; and
3. For mental health home health or personal care services, a listing of the actual dates and times the staff actually provided services and a progress note summarizing the service.

For psychological testing and evaluation services, unless otherwise instructed by Medicaid, the following must accompany all claims submitted to the Department for payment:

1. The treatment plan;
2. Clinical necessity for the service documented in the treatment plan; and
3. A narrative summary of the testing results (listing the tests administered).

32-002.13 Limitations on MHSA Community Treatment Aide Services: MHSA Community Treatment Aide Services must be ordered by the supervising practitioner. These services must be included in the treatment plan and must be reassessed at each treatment plan review -

1. MHSA Community Treatment Aide Services, Level I may not exceed eight hours per day, or 40 hours of care in a seven-day period;
2. MHSA Community Treatment Aide Services, Level II may not exceed 40 hours of care in a seven-day period;
3. Students - NMAP does not cover MHSA community treatment aide services provided by students who are enrolled in training or degree programs and are not employed by the service providing agency. Students may observe or provide services under the direct supervision of an employee of the service providing agency.

MHSA Community Treatment Aide Services staff may not be related to or live in the same household as the clients they specifically serve, but may provide services to clients to whom they are not related.

The hour limitation may be extended in very limited situations and must be prior authorized by Medicaid staff or their designee.

32-002.14 Inspections of Care: The Department's inspection of care team may conduct inspection of care reviews for Outpatient Mental Health and Substance Abuse Services. Please refer to 471 NAC 32-001.11 and 32-001.12.

32-002.15 Procedure Codes: HCPCS/CPT procedure codes used by NMAP are listed in the Nebraska Medicaid Practitioner Fee Schedule at 471-000-532.

32-003 Treatment Crisis Intervention Services: Crisis intervention services are available to clients age 20 or younger when the treatment of a condition needing care leads to a HEALTH CHECK (EPSDT) screen and the treatment is clinically necessary. Crisis intervention services are appropriate for a family in the midst of a child/adolescent mental health or substance abuse crisis. The interventions focus on reducing stress and helping resolve the crisis in a positive manner, and facilitating the client's involvement to treatment.

Crisis intervention services must meet all requirements in 471 NAC 32-001. All crisis intervention service providers must facilitate a referral for a complete HEALTH CHECK (EPSDT) screen within eight weeks of the crisis intervention. This referral must be documented in the client's clinical record.

Crisis intervention services must be family-centered, community-based, developmentally appropriate, culturally competent, and must take into account the individual needs of clients age 20 and younger.

Providers must encourage family members to be involved in the assessment of the client, the development of the treatment plan, and all aspects of the client's treatment unless prohibited by the client, through legal action, or because of federal confidentiality laws.

Providers must be available to schedule meetings and sessions in a flexible manner to accommodate and work with a family's schedule. This includes the ability to schedule sessions at a variety of times including weekends or evenings.

The provider must document their attempts to involve the family in treatment plan development and treatment plan reviews. A variety of communication means should be considered. These may include, but should not be limited to, including the family via conference telephone calls, using registered letters to notify the family of meetings, and scheduling meetings in the evening and on weekends.

32-003.01 Types of Crisis Intervention Services: One of the following services must be included in a crisis intervention program to be approved for participation in the Nebraska Medical Assistance Program.

32-003.01A Non-Residential Crisis Intervention: Non-residential crisis intervention services are provided to the family and client outside of a residential or institutional setting. This service includes supportive services therapy, brief assessment, and coordination services to help a family alleviate a crisis. These services must be directed by a supervising practitioner and psychiatric consultation must be readily available. Some assessment and intervention activities may be carried out by a clinical professional (see 471 NAC 32-001.04, item 2) who is acting within his/her scope of practice under the direction of a supervising practitioner.

The provider must have the capacity to respond to the family to unscheduled crisis intervention contacts 24 hours a day, seven days a week.

Providers of crisis intervention services must facilitate the referral to or provide the pre-treatment assessment (see 471 NAC 32-001.01) if it has not already occurred.

32-003.01B Day Residential Crisis Intervention: Day residential crisis intervention services are provided to families when a safe and secure setting is needed to provide a therapeutic milieu for a child or adolescent for up to 23 hours and 59 minutes. This level is used when a brief stay in a secure setting will facilitate a de-escalation of the crisis. These services must be directed by a supervising practitioner with access to psychiatric consultation. The milieu and direct care interventions may be staffed by clinical professionals (see 471 NAC 32-001.04) or technicians, under the direction of a supervising practitioner.

Providers of crisis intervention services must facilitate the referral to or provide the pre-treatment assessment (see 471 NAC 32-001.01) if it has not already occurred.

32-003.01C Residential Acute Crisis Intervention: Residential acute crisis intervention services are available to children and adolescents experiencing acute psychiatric crisis. The program provides crisis treatment and close supervision to stabilize a client and facilitate admission to the most appropriate treatment setting. These services must be directed under the cooperative supervision of a physician and other licensed practitioner of the healing arts. The milieu and direct care interventions may be staffed by clinical professionals (see 471 NAC 32-001.04) or technicians, under the direction of a supervising practitioner.

Providers of crisis intervention services must facilitate the referral to or provide the pre-treatment assessment (see 471 NAC 32-001.01) if it has not already occurred.

32-003.02 Standards for Participation as a Provider of Crisis Intervention Services: Programs shall meet the following standards to participate in the NMAP as a provider of crisis intervention service in addition to the standards listed in 471 NAC 32-001.03.

32-003.02A Provider Agreement: The provider shall submit the following with Form MC-19 (non-hospital) or Form MC-20 (hospital):

1. A written overview of the program's philosophy and objectives of treating youth including:
   a. A description of each available service;
   b. A list of treatment modalities available and the capacity for individualized treatment planning;
   c. A statement of qualification, education, and experience of each staff member providing treatment and the supervising practitioner and the therapeutic services each provides;
   d. A schedule covering the total number of hours that the program operates;
   e. A program overview, including admission criteria, staff training information, etc.; and
   f. Any other information requested by the Department;
2. Copies of licensure and certification, through the Nebraska Department of Health and Human Services, Division of Public Health, JCAHO, COA, AOA and/or CARF as appropriate.

32-003.02B Staffing Standards for Participation: An agency providing crisis intervention services for children and adolescents shall meet the following staffing standards to participate in NMAP:

1. All services must be provided under the supervision of the supervising practitioner. This practitioner must be available at all times for consultation or face-to-face client assessment.
2. Direct intervention services must be provided by a clinical staff person who is acting within his/her scope of practice (see 471 NAC 32-001.04).

32-003.02C Location of Services: Crisis intervention services may be provided in any of the following locations:

1. The client's home;
2. A physician's private office;
3. A community mental health program which meets the criteria for approval by JCAHO or is accredited by CARF, COA, or AOA, and is appropriately licensed by the Nebraska Department of Health and Human Services, Division of Public Health;
4. A hospital licensed and certified by the State of Nebraska which is accredited by JCAHO or AOA and has in effect a utilization review plan applicable to all Medicaid clients;
5. The private office of a licensed practitioner of the healing arts who is licensed by the Nebraska Department of Health and Human Services, Division of Public Health;
6. The client's school;
7. Other appropriate locations to meet the client needs for intervention;
8. A treatment foster home that is part of an agency enrolled to provide treatment foster care through Medicaid; or
9. A facility enrolled as a residential treatment center or therapeutic group home under this chapter (Mental Health and Substance Abuse Services for Children and Adolescents).

32-003.02D Annual Update: The provider shall submit the following information on an annual basis:

1. An overview of any changes in the program including any new services;
2. A current list of staff; and
3. Current copies of all licenses, letters of accreditation, and certifications.

32-003.03 Covered Services: Payment for crisis intervention services under the Nebraska Medical Assistance Program is limited to services for clinically necessary primary psychiatric diagnoses. The Department covers the following crisis intervention services:

1. Active treatment, which must be:
   a. Provided under the supervision of the supervising practitioner by clinical staff members acting within their scope of practice (see 471 NAC 32-001.04); and
   b. Reasonably expected to improve the client's condition or resolve the crisis. The treatment interventions must, at a minimum, be designed to reduce or control the client's symptoms to facilitate the resolution of a crisis or prevent the need for care in a more restrictive level of care.

32-003.03A Special Treatment Procedures in Crisis Intervention Services: If a child/adolescent needs behavior management and containment beyond unlocked time outs or redirection, special treatment procedures may be utilized. For Crisis Intervention Services provided in Treatment Foster Care, Residential Treatment Centers, or Treatment Group Homes, please refer to the sections covering those services. For Crisis Intervention Services provided in the child/adolescent's home, school, or other appropriate location, Special Treatment Procedures is limited to physical restraint. Mechanical restraints and pressure point tactics are not allowed. Parents, the legal guardian, or the Department case manager must approve use of these procedures and must be informed within 24 hours each time they are used.

Facilities must meet the following standards regarding special treatment procedures:

1. De-escalation techniques must be taught to staff and used appropriately before the initiation of special treatment procedures;
2. Special treatment procedures may be used only when a child/adolescent's behavior presents a danger to self or others, or to prevent serious disruption to the therapeutic environment; and
3. The child/adolescent's treatment plan must address the use of special treatment procedures and have a clear plan to decrease the behavior requiring intervention.

These standards must be reflected in all aspects of the treatment program. Attempts to de-escalate, the special treatment procedure and subsequent processing must be documented in the clinical record and reviewed by the supervising practitioner.

32-003.04 Admission Criteria: The provider of crisis intervention services shall develop admission criteria for the types of services they provide. The admission criteria must be approved by the Department Medicaid staff as part of the provider enrollment.

32-003.05 Documentation in Client's Medical Record: Providers of crisis intervention services must follow the standards for Clinical Records specified in 471 NAC 32-001.05.

Clinical records for crisis intervention services must also include, at a minimum, the following:

1. The referral source and description of the crisis;
2. The provider's plan to facilitate referrals to the appropriate ongoing care for the family; and
3. The follow-up contacts with the client and/or family.

32-003.06 Limitations: NMAP limits payment for crisis intervention to medically necessary services, subject to the Department's utilization review.

This period includes an average crisis resolution period of three to five days with an occasional need for up to seven days when the client's condition dictates. Payment for crisis intervention services is not available for services past seven days.

32-003.07 Payment for Crisis Intervention Services: Payment for crisis intervention services is made according to the Nebraska Medicaid Practitioner Fee Schedule at 471-000-532.

If crisis intervention services are provided in the home between the hours of 10:00 p.m. and 8:00 a.m., the fee will be paid at one and one half times the regular rate. This shift differential is only available for unscheduled emergency services that are part of a crisis intervention service.

32-004 Mental Health and Substance Abuse Day Treatment Services: Day treatment services are available to clients age 20 or younger when the client has participated in a HEALTH CHECK (EPSDT) screen, the treatment is clinically necessary, and the need for this level of care is identified as part of a pre-treatment assessment (see 471 NAC 32-001.01). These services are part of a continuum of care designed to prevent hospitalization or to facilitate the movement of the client in an acute psychiatric setting to a status in which the client is capable of functioning within the community with less frequent contact with the mental health or substance abuse provider.

Day treatment services must be community based, family centered, culturally competent, and developmentally appropriate.

Day treatment services must meet all requirements in 471 NAC 32-001.

Providers must encourage family members to be involved in the assessment of the client, the development of the treatment plan, and all aspects of the client's treatment unless prohibited by the client, through legal action, or because of federal confidentiality laws.

Providers must be available to schedule meetings and sessions in a flexible manner to accommodate and work with a family's schedule. This includes the ability to schedule sessions at a variety of times including weekends or evenings.

The provider must document their attempts to involve the family in treatment plan development and treatment plan reviews. A variety of communication means should be considered. These may include, but should not be limited to, including the family via conference telephone calls, using registered letters to notify the family of meetings, and scheduling meetings in the evening and on weekends.

32-004.01 Covered Day Treatment Services: Day treatment programs shall provide the following mandatory services and at least two of the following optional services. Payment for both mandatory services and optional services is included in the rate for day treatment. Individual services to the client by a supervising practitioner that are not administrative in nature and are clinically necessary will be considered for payment when billed by the supervising practitioner. Providers shall not make any additional charges to the Department or to the client.

32-004.01A Mandatory Services: The following services must be included in a program for day treatment to be approved for participation in the Nebraska Medical Assistance Program. See 471 NAC 32-001 for definitions.

1. Medically Necessary Psychotherapy and Substance Abuse Counseling Services: These services must demonstrate active treatment of a patient with a serious emotional disturbance. These services are subject to program limitations.
   a. Individual Psychotherapy or Substance Abuse Counseling;
   b. Group Psychotherapy or Substance Abuse Counseling;
   c. Family Psychotherapy or Substance Abuse Counseling; and
   d. Family Assessment;
2. Medically Necessary Nursing Services: Medical services provided by a Qualified Registered Nurse who evaluates the particular medical nursing needs of each client and provides for the medical care and treatment that is indicated on the Department approved treatment planning document and approved by the supervising practitioner.
3. Medically Necessary Psychological Diagnostic Services: Testing and evaluation services must reasonably be expected to contribute to the diagnosis and plan of care established for the individual client. Testing and evaluation services may be performed by a Licensed Psychologist, Specially Licensed Psychologist or a psychology resident acting within his/her scope of practice. Clinical necessity must be documented by the program supervising practitioner. Reimbursement for psychological diagnostic services is included in the per diem.
4. Medically Necessary Pharmaceutical Services: If medications are dispensed by the program, pharmacy services must be provided under the supervision of a registered pharmacy consultant; or the program may contract for these services through an outside facility or provider. All medications must be stored in a special locked storage space and administered only by a physician, registered nurse, or licensed practical nurse.
5. Medically Necessary Dietary Services: If meals are provided by a day treatment program, services must be supervised by a registered dietitian, based on the client's individualized diet needs. Day treatment programs may contract for these services through an outside facility or provider.
6. Transition and discharge planning that meets the requirements of 471 NAC 32-001.07A.

32-004.01B Optional Services: The program must provide two of the following optional services. The client must have a need for the services, the supervising practitioner must order the services, and the services must be a part of the client's treatment plan. The therapies must be restorative in nature, not prescribed for conditions that have plateaued or cannot be significantly improved by the therapy, or which would be considered maintenance therapy. In appropriate circumstances, occupational therapy may be covered if prescribed as an activities therapy in a day treatment program:

1. Services provided or supervised by a licensed or certified therapist may be provided under the supervision of a qualified consultant or the program may contract for these services from a licensed/certified professional as listed below:
   a. Recreational Therapy;
   b. Speech Therapy;
   c. Occupational Therapy;
   d. Vocational Skills Therapy;
   e. Self-Care Services: Services supervised by a registered nurse or occupational therapist who is oriented toward activities of daily living and personal hygiene. This includes toileting, bathing, grooming, etc.
2. Psychoeducational Services: Therapeutic psychoeducational services may be provided as part of a total program. Therapeutic psychoeducational services must be provided by teachers specially trained to work with child and adolescents experiencing mental health or substance abuse problems. These services may meet some strictly educational requirements, but must also include the therapeutic component. Professionals providing these services must be appropriately licensed and certified for the scope of practice.
3. Social Work Services by a Bachelor's Level Social Worker: Social services to assist with personal, family, and adjustment problems which may interfere with effective use of treatment, i.e., case management type services.
4. Crisis Intervention (may be provided in home);
5. Social Skills Building;
6. Life Survival Skills; and
7. Substance abuse prevention, intervention, or treatment by an appropriately certified alcohol/drug abuse counselor.

32-004.01C Educational Program Services: Services, when required by law, must be available, though not necessarily provided by the day treatment program. Educational services must be only one aspect of the treatment plan, not the primary reason for admission or treatment. Educational services are not eligible for payment by the Nebraska Medical Assistance Program (Medicaid), and do not apply towards the three hours or six hours of therapeutic services.

32-004.01D Special Treatment Procedures in Day Treatment: If a child/adolescent needs behavior management and containment beyond unlocked time outs or redirection, special treatment procedures may be utilized. Special treatment procedures in day treatment are limited to physical restraint, and locked time out (LTO). Mechanical restraints and pressure point tactics are not allowed. Parents or legal guardian or the Department case manager must approve use of these procedures through informed consent and must be informed within 24 hours each time they are used.

Facilities must meet the following standards regarding special treatment procedures:

1. De-escalation techniques must be taught to staff and used appropriately before the initiation of special treatment procedures;
2. Special treatment procedures may be used only when a child/adolescent's behavior presents a danger to self or others, or to prevent serious disruption to the therapeutic environment; and
3. The child/adolescent's treatment plan must address the use of special treatment procedures and have a clear plan to decrease the behavior requiring LTO, or physical restraints.

These standards must be reflected in all aspects of the treatment program. Attempts to de-escalate, the special treatment procedure and subsequent processing must be documented in the clinical record and reviewed by the supervising practitioner.

32-004.02 Standards for Participation

32-004.02A Provider Standards: Providers of day treatment services shall meet the following standards:

1. A community mental health or substance abuse program providing day treatment must meet the following standards -
   a. A community-based treatment facility appropriately licensed as determined by the Department of Health and Human Services, Division of Public Health;

b. Accreditation by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), the Commission on the Accreditation of Rehabilitation Facilities (CARF), the Council on Accreditation (COA) or the American Osteopathic Association (AOA). Agencies that have applied for accreditation may be enrolled on a provisional status; and

2. A psychiatric or substance abuse hospital providing day treatment must -
   a. Be maintained for the care and treatment of patients with primary psychiatric or substance abuse disorders;
   b. Be licensed or formally approved as a hospital by the Nebraska Department of Health and Human Services, Division of Public Health;
   c. Be accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) or the American Osteopathic Association (AOA);
   d. Have licensed and certified psychiatric or substance abuse beds;
   e. Meet the requirements for participation in Medicare; and
   f. Have in effect a utilization review plan applicable to all Medicaid clients.

3. A licensed and certified hospital which provides acute care services and which -
   a. Is maintained for the care and treatment of patients with acute medical disorders;
   b. Is licensed or formally approved as a hospital by the Nebraska Department of Health and Human Services, Division of Public Health;
   c. Is accredited by the Joint Commission on Accreditation of Healthcare Organizations(JCAHO) or the American Osteopathic Association (AOA);
   d. Meets the requirements for participation in Medicare for acute medical hospitals;
   e. Has in effect a utilization review plan applicable to all Medicaid clients; and
   f. Has adequate staff to meet the requirements of the mental health or substance abuse day treatment standards.

4. If day treatment services will be provided in a school, the school must have a written contract with a mental health or substance abuse program that meets these standards community mental health program or licensed hospital. This contract shall demonstrate the working relationship between the school and the community mental health or substance abuse program to provide the day treatment service.

32-004.02B Service Standards:

1. The program must provide a minimum of three hours of services five days a week, which is considered a half day for billing purposes. Six hours a day of services is considered a full day of services. Services may not be prorated for under three (or six) hours of services, but may be for up to 12 hours of service.
2. A designated supervising practitioner must be responsible for the care provided in a day treatment program. The supervising practitioner must be present on a regularly-scheduled basis and must assume responsibility for all clients. If the supervising practitioner is present on a part-time basis, one of the clinical staff professionals acting within the scope of practice standards of the Nebraska Department of Health and Human Services, Division of Public Health (see 471 NAC 32-001.04) shall assume delegated professional responsibility for the program and must be present at all times when the program is providing services.

   Psychotherapy and substance abuse counseling services must be provided by clinical staff (see 471 NAC 32-001.04) who are operating within their scope of practice and under the direction of the supervising practitioner. The supervising practitioner's personal involvement must be documented in the client's clinical record.
3. A licensed psychologist, physician, or doctor of osteopathy may refer a client to a day treatment program, but all treatment must be prescribed and directed by the program supervising practitioner.
4. All treatment must be conducted under the direction of the supervising practitioner in charge of the program;
5. Admission Criteria: The following criteria must be met for a client's admission to a day treatment program:
   a. The client must have sufficient need for active treatment at the time of admission to justify the expenditure of the client's and program's time, energy, and resources;
   b. Of all reasonable options for active treatment available to the client, treatment in this program must be the best choice for expecting a reasonable improvement in the client's condition;
6. Pre-Admission Assessment: Before the client is admitted to the program, a supervising practitioner and other staff shall complete a comprehensive pre-admission assessment to validate the appropriateness of care. This assessment is described in 471 NAC 32-001.01.
7. Treatment Plan: The program supervising practitioner shall determine the diagnosis and prescribe the treatment, including the modalities and the professional staff to be used. He/she must be responsible and accountable for all evaluations and treatment provided to the client.

The goals and objectives documented on the treatment plan must reflect the recommendations included in the Pre-treatment Assessment and the integration of input from the supervising practitioner and the therapist. The treatment interventions provided must reflect these recommendations, goals, and objectives. Evaluation of the treatment plan by the therapist and the supervising practitioner should reflect the client's response to the treatment interventions based on the recommendations, goals and objectives.

The multi-disciplinary team shall complete the treatment plan within the first 14 days after the client's admission to the program. The plan must be reviewed and revised by the multi-disciplinary team, including the supervising practitioner, at least every 30 days or more often if necessary.

Changes in the treatment plan must be noted on the treatment planning document. An updated treatment plan must be completed every 30 days, or more frequently if necessary, to reflect changes in treatment needs.

The treatment plan must be signed by the supervising practitioner for day treatment services.

The treatment plan review must be documented on the treatment plan, if required, and in the medical records.

8. The supervising practitioner must meet personally with the client for evaluation every 30 days, or more often, as clinically necessary. Reimbursement for the 30-day update visit is not included in the day treatment per diem and can be reimbursed separately.
9. Every 30 days a utilization review must be conducted per 471 NAC 32-004.07. This review must be documented on the treatment plan, and the facility's treatment plan review form. Utilization review is not required for the calendar month in which the client was admitted.
10. The program must have a description of each of the services and treatment modalities available. This includes psychotherapy services, substance abuse counseling, nursing services, psychological diagnostic services, pharmaceutical services, dietary services, and other day treatment services.
    a. The program must have a description of how the family-centered requirement in 471 NAC 32-001 will be met, including a complete description of any family assessment and family services.
    b. The program must have a description of how the community-based requirement in 471 NAC 32-001 will be met.
    c. The program shall state the qualifications, education, and experience of each staff member and the therapy services each provides.
    d. The program must have a daily schedule covering the total number of hours the program operates per day. The schedule must be submitted to the Department for approval. The program must be fully staffed and supervised during the time the program is available for services, and must provide at least three hours of approved treatment for each day services are provided. This schedule must be updated annually, or more frequently if appropriate.

11. Outpatient Observation: When appropriate for brief crisis stabilization, outpatient observation up to 23 hours 59 minutes in an emergency room or acute hospital may be used as follows:
    An outpatient is defined as a person who has not been admitted as an inpatient but is registered on the hospital records as an outpatient and receives services (rather than supplies alone). If a patient receives 24 or more hours of continuous outpatient care, that patient is defined as an inpatient regardless of the hour of admission, whether s/he used a bed and whether s/he remained in the hospital past midnight or the census-taking hour, and all inpatient prior-authorization requirements apply.
12. The program must have a written plan for immediate admission or readmission for appropriate inpatient services, if necessary. The written plan must include a cooperative agreement with a psychiatric or substance abuse hospital or distinct part of a hospital, as outlined in 471 NAC 32-008. A copy of this agreement must accompany the provider application and agreement.

32-004.03 Provider Agreement: A provider of day treatment services shall complete a provider agreement and submit the form to the Department for approval. The provider shall attach to the provider agreement a written overview of the program including philosophy, objectives, policies and procedures, and documentation of the requirements in 471 NAC 32-001 are met. Staff must meet the standards outlined in 471 NAC 32-001.04, and:

1. Community mental health or substance abuse programs and licensed health clinics shall complete Form MC-19, "Medical Assistance Provider Agreement," and submit the completed form to the Department for approval. A Department approved cost reporting document must also be submitted. Satellites of community programs shall bill the Department through their main community program, unless the satellite has a separate provider number under Medicare. A satellite of a community program that has a separate provider number under Medicare shall complete a separate provider agreement. All claims submitted to the Department by these satellites must be filed under the satellite's Medicaid provider number. The facility must have in effect a utilization review plan applicable to all Medicaid clients.
2. Hospitals shall complete Form MC-20, "Medical Assistance Hospital Provider Agreement," and submit the completed form to the Department for approval. A Department approved cost reporting document must also be submitted.

32-004.03A Annual Renewal/Update: The program shall renew the provider agreement, program overview, and cost report annually and whenever requested by the Medicaid Division.

32-004.04 Coverage Criteria for Mental Health or Substance Abuse Day Treatment Services: The Nebraska Medical Assistance Program covers day treatment services for clients 20 and younger when the services meet the requirements in 471 NAC 32-001 and the client has participated in a HEALTH CHECK (EPSDT) screen.

Day treatment services must be prior authorized by the Division of Medicaid and Long-Term Care or its designee.

The client must be observed and interviewed by the supervising practitioner at least once every 30 days, or more frequently if medically necessary, and the interaction must be documented in the client's clinical record.

32-004.04A Services Not Covered Under NMAP: Payment is not available for day treatment services for clients -

1. Receiving services in an out-of-state facility, except as outlined in 471 NAC 1-002.01F, Services Provided Outside Nebraska;
2. In long term care facilities;
3. Whose needs are social or educational and may be met through a less structured program;
4. Whose primary diagnosis and functional impairment is acutely psychiatric in nature and whose condition is not stable enough to allow them to participate in and benefit from the program; or
5. Whose behavior may be very disruptive and/or harmful to other program participants or staff members.

32-004.05 Documentation in the Client's Clinical Record: All documents submitted to NMAP must contain sufficient information for identification (i.e., client's name, dates of service, provider's name). In addition to the requirements of 471 NAC 32-001.05, each client's medical record must contain the following documentation:

1. The supervising practitioner's orders;
2. The treatment plan;
3. The team progress notes, recorded chronologically. The frequency is determined by the client's condition, but the team's progress notes must be recorded at least daily. The progress notes must contain a concise assessment of the client's progress and recommendations for revising the treatment plan, as indicated by the client's condition, and discharge planning.
4. Documentation indicating compliance with all requirements in 471 NAC 32-001;
5. Records of the treatment plan review by the multi-disciplinary team including attendees and decisions;
6. The program's utilization review committee's abstract or summary; and
7. The discharge summary.

32-004.06 Transition and Discharge Planning: Each provider must meet the 471 NAC 32-001.07A requirements for transition and discharge planning.

32-004.07 Utilization Review (UR): Each program is responsible for establishing a utilization review plan and procedure which meets the following guidelines. A site visit by Medicaid staff for purposes of utilization review may be required for further clarification.

32-004.07A Components of UR: Utilization review must provide -

1. Timely review (at least every 30 days) of the medical necessity of admissions and continued treatment;
2. Utilization of professional services provided;
3. High quality patient care; and
4. Effective and efficient utilization of available health facilities and services.

32-004.07B UR Overview: An overview of the program's utilization review process must be submitted with the provider application and agreement before the program is enrolled as a Medicaid provider. The overview must include -

1. The organization and composition of the utilization review committee which is responsible for the utilization review function;
2. The frequency of meetings (not less than once a month);
3. The type of records to be kept; and
4. The arrangement for committee reports and their dissemination, including how the program and supervising practitioner is informed of the findings.

32-004.07C UR Committee: The utilization review committee must contain a licensed practitioner of the healing arts who is able to diagnose and treat major mental illness within their scope of practice and at least two clinical staff professionals (as defined in 471 NAC 32-001). The committee's reviews may not be conducted by any person whose primary interest in or responsibility to the program is financial or who is professionally involved in the care of the client whose case is being reviewed. At the Department's discretion, an alternative plan for facilities that do not have these resources readily available may be approved.

32-004.07D Basis of Review: The review must be based on -

1. The identification of the individual client by appropriate means to ensure confidentiality;
2. The identification of the supervising practitioner;
3. The date of admission;
4. The diagnosis and symptoms;
5. The supervising practitioner's plan of treatment; and
6. Other supporting materials (progress notes, test findings, consultations) the group may deem appropriate.

32-004.07E Contents of Report: The written report must contain -

1. An evaluation of treatment, progress, and prognosis based on -
   a. Appropriateness of the current level of care and treatment;
   b. Alternate levels of care and treatment available; and
   c. The effective and efficient utilization of services provided;
2. Verification that -
   a. Treatment provided is documented in the client's record;
   b. All entries in the client's record are signed by the person responsible for entry and dated. The supervising practitioner shall sign and date all of his/her orders; and
   c. All entries in the client's record are dated;
3. Recommendations for -
   a. Continued treatment;
   b. Alternate treatment/level of care; and
   c. Disapproval of continued treatment.
4. The date of the review;
5. The names of the program utilization review committee members; and
6. The date of the next review if continued treatment is recommended.

A copy of the admission review and the extended stay review must be attached to all claims for mental health services submitted to the Department for payment.

32-004.08 Limitations on Reimbursement of Allowable Costs: The following limitations apply to reimbursement of allowable costs:

1. Payment for a full day of day treatment is allowable when services are provided to a client for at least six hours per day.
2. Payment for a half day of day treatment is allowable when services are provided to a client for at least three hours per day but less than six hours per day. The rate for a half day of day treatment is limited to one half of the "full day" rate.
3. For programs that provide services for more than six hours, and up to twelve hours, payment can be prorated by the hour. For each additional hour of service beyond six, NMAP will pay an additional amount based on the cost-report.

32-004.08A Documentation for Claims: The following documentation is required for all claims for day treatment/claims and must be kept in the client's record:

1. A psychiatric assessment with mental status exam and diagnosis;
2. The treatment plan, if required (required at admission and every 30 days thereafter);
3. Orders by the supervising practitioner;
4. A complete family assessment;
5. Nurses' notes; and
6. Progress notes for all disciplines.

All claims are subject to utilization review by the Department prior to payment.

32-004.08B Exception: Additional documentation from the client's medical record may be requested by the Department prior to considering authorization of payment.

32-004.08C Costs Not Included in the Day Treatment Fee: The mandatory and optional services are considered to be part of the fee for day treatment services. The following charges can be reimbursed separately from the day treatment fee when the services are necessary, part of the client's overall treatment plan, and in compliance with NMAP policy:

1. Direct client services performed by the supervising practitioner;
2. Prescription medications (including injectable medications);
3. Direct client services performed by a physician other than the supervising practitioner; and
4. Treatment services for a physical injury or illness provided by other professionals.

If the client is enrolled with another managed care vendor for medical-surgical services, it may be necessary to pursue prior authorization or referral with that entity.

32-004.09 Procedure Codes and Descriptions for Mental Health or Substance Abuse Day Treatment: HCPCS/CPT procedure codes used by NMAP are listed in the Nebraska Medicaid Practitioner Fee Schedule at 471-000-532.

32-005 Treatment Foster Care Services: Treatment foster care services are available to clients age 20 or younger when the client has participated in a HEALTH CHECK (EPSDT) screen, the treatment is clinically necessary, and the pre-treatment assessment documents the need for continued care of this level. Treatment foster care occurs in a foster home when specially trained foster parents are available at all times to provide consistent behavior management programs, therapeutic interventions, and render services under the direction of a supervising practitioner. Treatment foster care services must be community-based, family focused, culturally competent, and developmentally appropriate. Treatment is provided within a family environment with services that focus on improving the client/family's adjustment emotionally, behaviorally, socially, and educationally. To be eligible to receive treatment in a treatment foster care program, the client must participate in a HEALTH CHECK (EPSDT).

Providers must encourage family members to be involved in the assessment of the client, the development of the treatment plan, and all aspects of the client's treatment unless prohibited by the client, through legal action, or because of federal confidentiality laws.

Providers must be available to schedule meetings and sessions in a flexible manner to accommodate and work with a family's schedule. This includes the ability to schedule sessions at a variety of times including weekends or evenings.

The provider must document their attempts to involve the family in treatment plan development and treatment plan reviews. A variety of communication means should be considered. These may include, but should not be limited to, including the family via conference telephone calls, using registered letters to notify the family of meetings, and scheduling meetings in the evening and on weekends.

32-005.01 Definitions: The following definitions and descriptions apply to treatment foster care services:

Agency Staff: Treatment foster care requires agency staff who are qualified, trained, and supported to implement the treatment model. Some treatment foster care initiatives have been undertaken in which one or a few staff with duties in other program areas assume responsibility for additional treatment foster care cases. Such arrangements tend to dilute the time, resources, and support available to the TFC Specialist and to the intensity and focus of the services provided. This does not constitute a true program of treatment foster care. A treatment foster care program must have an adequate number of staff to provide administration and direct services. See 471 NAC 32-001.04 for further staff requirements.

Children and Adolescents: Treatment foster care serves clients age 20 or younger whose special needs cannot be met in their own families and who require out-of-home care. In addition to providing treatment for specific problems or conditions, treatment foster care seeks to promote a permanent family living arrangement for the children and youth it serves.

Family Treatment: Treatment foster care programs also serve the families of the children and adolescents in their care. Treatment foster care programs seek to involve children and families in treatment-planning and decision making as members of the treatment team. They provide family services to children and their families when return home is planned, and actively seek to support and enhance children's relationships with their parents, siblings, and other family members throughout the period of placement regardless of the permanency goal unless such efforts are expressly and legally prohibited.

TFC Program: A program of treatment foster care is a coherent, integrated constellation of services specifically designed to provide treatment within the foster home setting. The term program implies a discreet organizational entity with clearly stated purposes and means of achieving them which are logically described and justified within the framework of a consistent treatment philosophy. As a program, treatment foster care is agency lead and team oriented.

Treatment: Treatment is the coordinated and planned provision of services and use of procedures designed to produce a planned outcome in a person's behavior, attitude, or general condition based on a thorough assessment of possible contributing factors. Treatment typically involves the teaching of adaptive, pro-social skills and responses which equip young persons and their families with the means to deal effectively with conditions or situations which have created the need for treatment. The term treatment presumes stated, measurable goals based on professional assessment, a set of written procedures for achieving them, and a process for assessing these results. Treatment accountability requires that goals and objectives be time limited and outcomes systematically monitored.

Treatment Foster Family: The treatment foster family is viewed as the primary treatment setting, with treatment parents trained and supported to implement the in-home portion of the treatment plan and promote the goals of permanency planning for children in their care. The treatment foster parents provide the main behavioral intervention and are available at all times. (At least one TFC parent per home must be considered a professional TFC parent whose time is dedicated to the TFC program.) While their role is essential to the model, treatment parents do not carry primary or exclusive responsibility for the design of treatment plans. This is a team function carried out under the clinical direction of qualified program staff.

32-005.02 Standards of Participation for Service Providers: The Nebraska Medical Assistance Program does not pay for care that is chronic or custodial. An agency that provides treatment foster care services shall meet the following standards for participation to ensure that payment is made only for active treatment:

1. The agency shall meet the standards in 471 NAC 32-001 and 471 NAC 32-005;
2. The treatment foster homes shall meet the minimum regulations for foster homes caring for children and be licensed through the Department (see 474 NAC 6-003) or approved by the placing agency;

3. The agency providing treatment foster care must be licensed as a Child Placing Agency (see 474 NAC 6-005);
4. The agency's records must be sufficient to permit the Department to determine the degree and intensity of treatment services furnished to the client/family;
5. The agency shall meet staffing requirements the Department finds necessary to carry out an active treatment program;
6. The program is designed to meet the developmental needs of persons age 20 and younger;
7. The program must provide for both planned and unplanned respite care services; and
8. The place of service must be the treatment foster family home.

32-005.02A Provider Agreement: A provider of treatment foster care (TFC) services shall complete a provider agreement, Form MC-19 or Form MC-20, "Medical Assistance Provider Agreement," and submit the completed form along with a program plan to the Department for approval. The provider application and agreement must be renewed annually to coincide with the submittal of the cost report (see 471 NAC 32-005.09).

An outline of the information required in a program plan is available from the Division of Medicaid and Long-Term Care.

If an agency providing treatment foster care is licensed, certified, or accredited through another agency (Department of Health and Human Services, Division of Public Health, Joint Commission on Accreditation of Health Care Organizations (JCAHO), etc.), the provider shall maintain this and provide a current copy for verification.

Agencies providing treatment foster care must be appropriately licensed by the Department of Health and Human Services, Division of Public Health.

32-005.02B Annual Renewal/Update: The program will submit information with the provider agreement (see 471 NAC 32-005.02A) and update the information annually and whenever requested by the Division of Medicaid and Long-Term Care.

32-005.03 Guidelines for Use of the Treatment Foster Care Services for Children: A youth must have a diagnostic condition listed in the current diagnostic and statistics manual of the American Psychiatric Association (excluding V-codes and developmental disorders) for this level of care. NMAP applies the following general guidelines to determine when treatment foster care services for children are clinically necessary for a client:

1. Utilization of treatment foster care is appropriate for individualized treatment and is expected to improve the client's condition to facilitate moving the client to a less restrictive placement;
2. The child/youth's problem behaviors are persistent but can be managed with this moderate level of structure;
3. The child/youth's daily functioning is moderately impaired in such areas as family relationships, education, daily living skills, community, health, etc.;
4. The child/youth has a history of previous problems due to ongoing inappropriate behaviors or psychiatric symptoms; or
5. Less restrictive treatment approaches have not been successful (see 42 CFR 441.152) or are deemed inappropriate by the supervising practitioner or treatment in a more restrictive setting has helped stabilize the client's behavior or psychiatric symptoms and they are ready to transition to a less restrictive level of care.

32-005.04 Staffing Standards for Participation

32-005.04A Staff Members: The following staff positions must be included in a treatment foster care program description. All staff must be operating within the scope of practice guidelines established by the Nebraska Department of Health and Human Services, Division of Public Health; alcohol and drug abuse counselors are licensed by HHS.

32-005.04A1 TFC Supervisor: The role of the TFC supervisor is to provide support and consultation to the treatment team and caseworker.

1. TFC supervisor responsibilities are -
   a. TFC Specialist supervision: The TFC supervisor will provide regular support and guidance to the caseworker through regular supervisory meetings and informal contact as needed. This TFC supervisor/specialist ratio must not exceed 1 to 6 and must be adjusted to accommodate for variables such as the severity of clients served or by the experience/qualifications of the casework staff.
   b. Treatment planning: The TFC supervisor is a member of the treatment team and shares the responsibilities of developing the plan. S/he also evaluates progress reports and updates.
   c. Crisis on-call: The TFC supervisor provides coordination and back-up to ensure that 24-hour on-call crisis intervention services are available and delivered to treatment families and client families.
   d. Other: May include but is not limited to any of the following:
      (1) Case management;
      (2) Case assessment;
      (3) Parent support and consultation;
      (4) Clinical and administrative supervision of staff;
      (5) Treatment parent recruitment;
      (6) Orientation;
      (7) Training and selection;
      (8) Youth intake and placement;
      (9) Record keeping;
      (10) Program evaluation;
2. TFC supervisor activities must be performed by a clinical staff member as defined in 471 NAC 32-001.04 who is acting within his/her scope of practice.

32-005.04A2 TFC Specialist: The TFC specialist is the practical leader of the treatment team and works in development of the treatment plan, supports and consults with the treatment families, client families, and other members of the treatment team. The TFC specialist also advocates for, coordinates, and links treatment families and client families to other services available in the community.

1. TFC specialist responsibilities:
   a. Treatment team:
      (1) Under the direction of the supervising practitioner and the TFC supervisor, the TFC specialist takes primary day-to-day responsibility for leadership of the treatment team. The TFC specialist organizes and manages all team meetings and team decision making. The TFC specialist takes an active role in identifying goals and coordinating treatment services provided to the youth.
      (2) The TFC specialist provides information and training to treatment team members who may not be familiar with the treatment foster care model. The TFC specialist prepares these individuals to work with treatment parents and client families in a manner which is supportive of their roles. The TFC specialist also prepares them to work with the team in a manner consistent with the treatment foster care practice and values.
   b. Treatment planning: The TFC specialist takes primary responsibility for the preparation of each client/family's written comprehensive treatment plan and the written updates of the plan. The TFC specialist seeks to inform and involve other team members in this process including treatment parents and the client family.
   c. Support/consultation to treatment parents:
      (1) The TFC specialist will provide regular support and technical assistance to the treatment parents in their implementation of the treatment plan and with regard to other responsibilities they undertake. The fundamental components of technical assistance will be the design or revision of in-home treatment strategies including proactive goal setting and planning, the provision of ongoing child-specific skills training, and problem solving during home visits.

(2) Other types of support/supervision include emotional support and relationship building, the sharing of information and general training to enhance professional development, assessment of the client's progress, observation/assessment of family interactions and stress, and assessment of safety issues. The TFC specialist will provide at least weekly contact by phone or in person with the treatment parent of each client family on his/her caseload. The TFC specialist will visit the treatment home to meet with at least one TFC parent no less than twice per month, or more often as is necessary.

d. Caseload: The number of client/families assigned to a TFC specialist is a function of: the size/density of the geographic area, the array of job responsibilities assigned, and the difficulty of the population served. The preferred maximum number of youth that may be assigned to a single TFC specialist is ten (individuals or siblings strips). (Flexibility within this standard is possible and will be considered on an individual program basis.)

e. Contact with client/family: The TFC specialist or other program staff shall regularly spend time alone with the client/families to allow them opportunity to communicate special concerns, to make direct assessment of their progress, and to monitor for potential abuse. The face-to-face contact must occur monthly, or more often based on the current needs of the client/family and the treatment parents and applies on an individual client/family basis.

f. Support/consultation of the client/families: The TFC specialist will seek support and enhance the client's relationships with his/her family during his/her time in treatment foster care. The TFC specialist will arrange and encourage regular contact and visitation as specified in the treatment plan. The TFC specialist will seek to include the client/family in treatment team meetings, treatment planning, and decision making, and will keep them informed of the client's progress.

g. Community liaison and advocacy: The TFC specialist will work with the treatment team to determine which community resources will help meet the needs of the client/families to meet the objectives of the treatment plan. The TFC specialist will advocate for and coordinate these services while providing technical assistance to the community agency.

h. Crisis on-call: The TFC specialist will work with other professionals on the team to coordinate 24-hour crisis coverage.

2. TFC specialist activities must be performed by a clinical staff member as defined in 471 NAC 32-001.04 who is acting within his/her scope of practice.

32-005.04A3 Other Members of the Agency Staff: These are recommended parts of the agency staff and several areas may be covered by one staff member:

1. Staff development and training;
2. Administrative support;
3. Consultants, including -
   a. Psychiatrist;
   b. Psychologist;
   c. Educational;
   d. Substance abuse;
   e. Sexual abuse;
   f. Family systems;
   g. Recreation therapist; and
   h. Legal; and
4. Respite care staff.

32-005.04A4 Supervising Practitioner: The role of the supervising practitioner is to support and supervise the treatment team in providing active treatment to the client/family.

1. The supervising practitioner must be a licensed practitioner of the healing arts who is able to diagnose and treat major mental illness within his/her scope of practice and must maintain this licensure in the state in which the program operates (see 471 NAC 32-001.04, Staffing Standards);
2. Supervising practitioner responsibilities:
   a. Treatment team participation: The supervising practitioner will provide regular support and guidance to the treatment team through team meetings;
   b. Treatment planning: The supervising practitioner helps in the development of a comprehensive treatment plan based on a thorough assessment for each client/family admitted to the program and input provided by the multidisciplinary team. S/he also participates in ongoing treatment planning and implementation for each client/family, as appropriate;
   c. Crisis on-call: The supervising practitioner provides consultation for on-call staff and foster parents. The supervising practitioner also helps coordinate emergency psychiatric hospitalizations when necessary and works with or is the admitting physician; and
   d. Client contact: The supervising practitioner will meet with the client/family as described in the treatment plan to assess the client's needs and monitor progress toward goals.

32-005.04B Staff Training and Support: All professional staff require preservice and ongoing professional development relevant to the treatment foster care model and to their individual job responsibilities. The staff training plan must be approved by the Department.

32-005.04B1 Crisis On-Call: The program shall provide on-call crisis intervention support to supplement that provided by the TFC supervisor and specialist to allow for 24-hour coverage and to avoid staff burnout.

32-005.04B2 Liability Insurance: Professional staff must be covered by liability insurance.

32-005.04B3 Legal Advocacy and Representation: The agency shall assist staff in obtaining legal advocacy and representation should the need arise in connection with the proper performance of their professional duties.

32-005.04B4 Respite Care: The program shall provide for planned and unplanned respite care for clients and treatment foster parents.

32-005.04C Treatment Parents: Treatment parents are members of the treatment team whose primary responsibility is to implement the specific strategies of the treatment plan. Their responsibilities also include providing parenting duties as outlined in state and agency regulations concerning foster parents. A treatment parent must be available 24 hours a day to respond to crisis or emergency situations. This may preclude one of the foster parents from working outside of the home. Treatment parents may not provide day care for children in their home.

32-005.04C1 Treatment Parent Responsibilities:

1. Foster role: Treatment duties encompass the basic parenting duties typically required of foster parents. These include, but are not limited to -
   a. Nutrition;
   b. Clothing;
   c. Shelter and physical care;
   d. Nurturance and acceptance;
   e. Supervision; and
   f. Transportation;
2. Treatment planning: The treatment parents shall assist the team in development of treatment plans for the client/family in their care. Treatment parents contribute vital input based upon their observations of the client/family in the natural environment of the treatment home;
3. Treatment implementation: The treatment parents have the primary responsibility for implementing the interventions identified in the treatment plan;

4. Treatment team meetings: The treatment parents shall work cooperatively with other team members and will attend team meetings, training sessions, and other meetings required by the program by the child's treatment plan;
5. Record keeping: The treatment parent shall systematically record information and document activities as required by the agency and the standards under which it operates. The treatment parent shall keep a systematic record of the client/family's behavior and progress in targeted areas on a daily basis (or more often as medically necessary);
6. Contact with child's family: The treatment parent shall assist the client in maintaining contact with his/her family and work actively to enhance and support these relationships as identified in the treatment plan;
7. Permanency planning assistance: The treatment parent shall assist with efforts specified by the treatment team to meet the child's permanency planning goals. These must include, but are not limited to -
    a. Emotional support;
    b. Advice;
    c. Demonstration of effective child behavior management and other therapeutic interventions to the child's family; and
    d. Support to the child and family during the initial period of post-treatment foster care placement.
8. Community relations: The treatment parent shall develop and maintain positive working relationships with service providers in the community such as schools, departments of recreation, social service agencies, and mental health programs and professionals;
9. Advocacy: The treatment parent shall work with other members of the treatment team to advocate on behalf of the child/family to achieve the goals identified in the treatment plan. This includes obtaining educational, vocational, medical, and other services needed to implement the treatment plan and to assure full access to and provision of public services to which the child is legally entitled; and
10. Notice of request for child move: Unless a move is required to protect the health and safety of the child or other treatment family members, the treatment parent shall provide at least 14 days' notice to program staff if requesting a child's removal from the home so as to allow for a planful and minimally disruptive transition.

32-005.04C2 Treatment Parent Selection: Treatment parents are selected in part on the basis of their acceptance of the program's treatment philosophy and their ability to practice or carry out this philosophy on a daily basis. They must be willing to accept the intense level of involvement and supervision provided by the treatment team in their treatment parenting functions and the impact of that involvement on their family life. Treatment parents must be willing to carry out all tasks specified in their treatment foster care program's job description including working directly and in a supportive fashion with the families of children placed in their care.

The program shall have a written policy explaining the procedures and criteria for treatment parent selection.

32-005.04C3 Treatment Parent Training: Treatment parent training must be a systematic, planned, and documented process which includes competency-based skill training and is not limited to the provision of information through didactic instruction. Training must be consistent and with the program's treatment philosophy and methods. It should prepare treatment parents to carry out their responsibilities as agents to the treatment process. The Treatment Parent and Respite Care staff training curriculum must be approved by the Department. The training must include the following components:

1. Preservice training: Prior to the placement of children in their homes, all treatment parents must complete the following training requirements:
   a. Basic: Treatment parents must satisfactorily complete the preservice training required of all foster parents; and
   b. Agency specific: 20 hours of agency specific primarily skill-based training consistent with the agency's treatment methodology and the service needs of the child.
2. In-service training: Each treatment parent must have a written educational plan, developed by the treatment foster care parent and their supervisors, on record which describes the content and objectives of in-service training. All treatment parents must complete a minimum of 12 hours of in-service training annually based on the specific training needs identified in the development plan and specific services treatment parents are required to provide. In-service training must emphasize skill development as well as knowledge acquisition and may include a variety of formats and procedures including in-home training provided by agency casework staff.

Respite care staff must be trained appropriately, as defined by the treatment program.

32-005.04C4 Treatment Parent Support: Treatment foster care programs are obligated to provide intensive support, technical assistance, and supervision to all treatment parents. This must include specific management and supervision services in addition to those listed below:

1. Information disclosure: All information the treatment foster care program receives concerning a client/family to be placed with a treatment family must be shared with and explained to the prospective TFC family prior to placement. Treatment parents have access to full disclosure of information concerning the child as well as the responsibility to maintain agency standards of confidentiality regarding such information. The information must include, but is not limited to -
   a. The child's strengths and assets;
   b. Potential problems and needs; and
   c. Initial intervention strategies for addressing these areas.
2. Respite: Respite care must be available at both planned and crisis times. The respite care provider must be trained according to the standards set by the treatment foster care program. The respite care providers must be informed of the client/family treatment plan and supervised in their implementation of the specific in-home strategies. There is no additional payment for respite care as this is a cost that must be included in the annual cost report.
3. Other support (the cost of these supports must be included in the cost report):
   a. Counseling: During their tenure as Treatment Families, treatment families must have access to counseling and therapeutic services arranged by the treatment foster care program for personal issues or problems caused or exacerbated by their work as treatment families. These issues may include marital stress or abuse of their own children by a client/family in their care.
   b. Peer support: The treatment foster care program shall facilitate the creation of support networks for treatment foster families (these may include formal groups, informal meetings, of "buddy" systems).
   c. Financial support: The treatment foster care program financial support to treatment parents must cover the cost of care associated with their treatment responsibilities and special needs of the client/family. The additional financial support given to treatment parents is directly related to the special skills, functions, and responsibilities required of them in fulfilling their roles as treatment parents. This is above and beyond the payment covering room, board, and care costs.

d. Damages and liability: The treatment foster care program shall have a written plan concerning compensation for damages done to a treatment family's property by client/families placed in their care. This plan must be provided as part of their preservice orientation. The agency shall provide liability coverage or assist the treatment family in obtaining it. Treatment foster parents are required to show documentation of coverage for home/apartment, vehicle (if appropriate), property, and liability insurance in addition to any coverage provided by or through the treatment foster care program.
e. Legal advocacy: The treatment foster care program shall assist treatment parents in obtaining legal advocacy for matters associated with the proper performance of their role as treatment parents.

32-005.05 Covered Services for Treatment Foster Care: Payment for treatment foster care services under the Nebraska Medical Assistance Program is limited to payment for necessary treatment services for diagnosable conditions. NMAP shall pay for treatment provided to ameliorate or correct the diagnosed condition. NMAP does not make payment for care that is primarily chronic or custodial in nature.

32-005.05A Coverage Criteria: The Department covers treatment foster care services when the following criteria are met. The services must be -

1. Active Treatment, which must be -
   a. Treatment provided under a Department approved treatment planning document developed by the multidisciplinary treatment team based on a thorough evaluation of the client's restorative needs and potentialities, including the developmental needs of clients age 20 or younger. The multidisciplinary treatment team includes the supervising practitioner, the TFC specialist, the TFC parent, and other staff as necessary. The treatment plan must be retained in the client's record.

      The treatment plan must be completed within 14 days of the client's admission to treatment foster care. The goals and objectives documented on the treatment plan must reflect the recommendations included in the Pre-treatment Assessment and the integration of input from the supervising practitioner and the therapist. The treatment interventions provided must reflect these recommendations, goals, and objectives. Evaluation of the treatment plan by the therapist and the supervising practitioner should reflect the client's response to the treatment interventions based on the recommendations, goals and objectives.
   b. Reasonably expected to improve the client's medical condition or to determine a diagnosis. The treatment must, at a minimum, be designed to correct or ameliorate the client's symptoms to facilitate the movement of the client to a less restrictive environment within a reasonable period of time.
   c. Consistent with the requirements listed in 471 NAC 32-001.06.

2. Necessary Treatment Services, which must be an appropriate level of care based on documented evaluations, including a comprehensive diagnostic work up and team-ordered treatment.
3. Generally limited to one treatment child per home, or one sibling strip of up to two children. Programs may place more than one child or sibling strip of more than two only after specific review by the treatment team and prior authorization through the Division of Medicaid and Long-Term Care.
4. Therapeutic passes for client involved in TFC. Therapeutic passes are an essential part of the treatment for client/families involved in treatment foster care. Documentation of the client's continued need for treatment foster care must follow overnight therapeutic passes. Therapeutic passes must be indicated in the treatment plan as they become appropriate. NMAP reimburses for only 60 therapeutic pass days per client, per year. This includes all treatment services in which the client is involved during the year.

Therapeutic leave days are counted by the entity reimbursing for the care. Because the NMAP fee-for-service program reimburses for therapeutic leave days on a post-service basis and because providers have one year to bill for services, the Department cannot guarantee that an accurate account of the therapeutic leave days that have been used.

In the event that a client does require hospitalization while in treatment foster care, NMAP will reimburse the treatment program for up to 15 days per hospitalization. This reimbursement is only available if the treatment placement is not used by another client.

32-005.05B Special Treatment Procedures in Treatment Foster Care: If a child/adolescent needs behavior management and containment beyond time outs or redirection, special treatment procedures may be utilized. Special treatment procedures in treatment foster care is limited to physical restraint. Mechanical restraints and pressure point tactics are not allowed. Parents or legal guardian or the Department case manager must approve use of this procedure through informed consent and must be informed within 24 hours each time they are used.

Treatment Foster Care Programs must meet the following standards regarding special treatment procedures:

1. De-escalation techniques must be taught to staff and TFC parents and used appropriately before the initiation of special treatment procedures;
2. Special treatment procedures may be used only when a child/adolescent's behavior presents a danger to self or others, or to prevent serious disruption to the therapeutic environment; and
3. The child/adolescent's treatment plan must address the use of special treatment procedures and have a clear plan to decrease the behavior requiring physical restraints.

These standards must be reflected in all aspects of the treatment program. Attempts to de-escalate, the special treatment procedure and subsequent processing must be documented in the clinical record and reviewed by the supervising practitioner.

32-005.06 Intake Process: Treatment foster care services are available to clients age 20 or younger when the condition needing care has been identified during a HEALTH CHECK (EPSDT) screen, the treatment is clinically necessary, the need for this level of care has been identified in the pre-treatment assessment, and the client has a serious emotional disturbance as indicated by the following:

1. The youth must have a diagnosable condition under the current Diagnostics and Statistics Manual of the American Psychiatric Association, and that condition is seen as primarily responsible for the client's problems;
2. The condition must result in substantial functional limitations in two or more of the following areas:
   a. Self care at an appropriate developmental level;
   b. Perception and expressive language;
   c. Learning;
   d. Self-direction, including behavioral controls, decision-making judgment, and value systems; and
   e. Capacity for living in a family environment.

32-005.06A Intake Criteria: The following criteria must be met for a client's admission to a treatment foster care program:

1. The need for treatment foster care must be identified on a pre-treatment assessment (see 471 NAC 32-001.01), based on the following criteria:
   a. The client must have sufficient need for active treatment at the time of intake to justify the expenditure of the client/family's and program's time, energy, and resources;
   b. Of all reasonable options for active treatment available to the client, active treatment in this program must be the best choice for expecting reasonable improvement in the client's condition;
2. The proposed or revised treatment plan must be the most efficient and appropriate use of the program to meet the client/family's particular needs;
3. The plan must address active and ongoing involvement of the family in care provision; and
4. The program is designed to meet the needs of clients age 20 and younger.

32-005.07 Preadmission Authorization and Continued Stay Review

32-005.07A Preadmission Authorization: For treatment foster care services to be covered by NMAP, the need for admission to this level of care must be precertified by a licensed practitioner of the healing arts who is able to diagnose and treat major mental illness within his/her scope of practice through an Initial Diagnostic Interview and prior authorized through the Division of Medicaid and Long-Term Care.

32-005.07B Prior Authorization: Treatment Foster Care Services must be prior authorized by the Division of Medicaid and Long-Term Care or its designee.

32-005.07C Continued Stay Review/Utilization Review: Each program is responsible for establishing a utilization review plan and procedure. A site visit by Medicaid and/or Health and Human Services staff for purpose of utilization review may be required for further clarification and review for payment (see 471 NAC 32-001.11).

32-005.08 Documentation

32-005.08A Treatment Plan: The treatment plan must be developed within the first 14 days after the client's admission to the program. The plan must be reviewed by the multi-disciplinary team at least every 30 days thereafter.

The multi-disciplinary treatment team consists of the treatment parent, the TFC specialist, the supervising practitioner, and other persons as necessary (parents, Department case manager).

Copies of the treatment plan must be retained in the client's record.

The treatment plan retained in the client's record must include -

1. The client's name;
2. The client's Medicaid number;
3. An indication if the client is a Department ward;
4. Date of the HEALTH CHECK during which the condition was disclosed;
5. The name of the referring physician (EPSDT);
6. The client's gender;
7. The client's age;
8. An indication if this is an initial or updated document;
9. The date of the initial diagnostic interview;
10. The date of the last report;
11. The date of this report;
12. Current active symptoms and/or functional impairments;
13. Date of onset of current acute condition;
14. An indication of whether this service was court-ordered (a copy of the court order must be attached);
15. An indication of whether psychological testing and/or a substance abuse evaluation has been completed (a copy of the results must be included);
16. Associated medical, legal, social, educational, occupational, or other problems;
17. Consultations;
18. Diagnoses;
19. Progress or complications since last report, including the client/family's participation in treatment;
20. Short term goals;

21. Long term goals;
22. Therapeutic interventions prescribed by the treatment team (frequency and by whom) including:
    a. Family therapy, training, and visits;
    b. Behavioral management;
    c. Individual counseling; and
    d. Group counseling;
23. Medication prescribed, physician monitoring medication, frequency, and dose;
24. The estimated length of stay at this level of care;
25. Placement and discharge plan;
26. Prognosis and brief explanation;
27. The provider's name; and
28. The provider's Medicaid number.

The treatment plan must be signed by the supervising practitioner.

32-005.08B Documentation in the Client's Clinical Record: Each client/family's clinical record must contain the following information:

1. The treatment plan;
2. The team progress notes, recorded chronologically. The frequency is determined by the client's condition, but the progress notes must be recorded at least daily. The progress notes must contain a concise assessment of the client/family's progress and recommendations for revising the treatment plan, as indicated by the client/family's condition, and discharge planning;
3. The program's utilization review committee's abstract or summary;
4. The discharge summary; and
5. Other documentation as required in 471 NAC 32-001.05.

32-005.09 Procedure Codes and Descriptions for Treatment Foster Care: HCPCS/CPT procedure codes used by NMAP are listed in the Nebraska Medicaid Practitioner Fee Schedule at 471-000-532.

32-005.10 Costs Not Included in the Treatment Foster Care Per Diem: The mandatory, family therapy and optional services are considered to be part of the per diem for TFC. The following charges can be reimbursed separately from the TFC per diem when the services are necessary, part of the client's overall treatment plan, and in compliance with NMAP policy:

1. Direct client services performed by the supervising practitioner;
2. Prescription medications (including injectable medications);
3. Direct client services performed by a physician or psychologist other than the supervising practitioner;
4. Treatment services for a physical injury or illness provided by other professionals; and
5. Other necessary treatment interventions including individual or group therapy and day treatment services.

If the client is enrolled with another managed care vendor for medical-surgical services, it may be necessary to pursue prior authorization or referral with that entity.

The TFC per diem does not include room and board costs.

32-005.11 Services Not Covered: Payment is not available for treatment foster care for clients -

1. Receiving services in an out-of-state facility, except as outlined in 471 NAC 1-004.04, Services Provided Outside Nebraska;
2. Whose needs are social or educational and may be met through a less structural program;
3. Whose primary diagnosis and functional impairment is so severe in nature and whose condition is not stable enough to allow them to participate in and benefit from the program; or
4. Whose behavior may be very disruptive and/or harmful to themselves, other program participants, or staff members.

32-005.12 Inspections of Care: The Department's inspection of care team may conduct inspection of care reviews for Treatment Foster Care Services. Please refer to 471 NAC 32-001.08 and 32-001.09.

32-006 Treatment Group Home

32-006.01 Introduction and Legal Basis: Treatment group home services are available to clients age 20 or younger when the client has participated in a HEALTH CHECK (EPSDT) screen, the treatment is clinically necessary, and the need for this level of care has been identified as part of a pre-treatment assessment (see 32-001.01). Treatment group homes are non-hospital based treatment services that are community-based, family-centered, and culturally competent.

Treatment group home services for children and adolescents covered by NMAP include treatment group home services for children age 20 and younger who are eligible for Medicaid. The policy in this section also covers children age 18 or younger who are wards of the Department.

Treatment group home services must be recommended by a licensed practitioner of the healing arts who is able to diagnose and treat major mental illness within his/her scope of practice for reduction of physical or mental disability, to restore a recipient to a better level of functioning, and to facilitate discharge to a less restrictive level of care.

32-006.02 Treatment Group Home Services for Children: The Department's philosophy is that all care provided to clients must be provided at the least restrictive and most appropriate level of care. Care must be developmentally appropriate, family-centered, culturally competent and community based. It must directly involve the immediate family in all phases of treatment and discharge planning. Family may include biological, step, foster, or adoptive parents, sibling or half sibling, and extended family members as appropriate.

Providers must encourage family members to be involved in the assessment of the client, the development of the treatment plan, and all aspects of the client's treatment unless prohibited by the client, through legal action, or because of federal confidentiality laws.

Providers must be available to schedule meetings and sessions in a flexible manner to accommodate and work with a family's schedule. This includes the ability to schedule sessions at a variety of times including weekends or evenings.

The provider must document their attempts to involve the family in treatment plan development and treatment plan reviews. A variety of communication means should be considered. These may include, but should not be limited to, including the family via conference telephone calls, using registered letters to notify the family of meetings, and scheduling meetings in the evening and on weekends.

Care must involve a representative from the appropriate home community service providers. This may include such areas as education, social services, law enforcement, religion, medical, and mental health professionals. NMAP will cover more restrictive levels of care only when all other resources have been explored and deemed to be inappropriate. If hospital-based inpatient care is deemed appropriate, see 471 NAC 32-008. If psychiatric residential treatment services are deemed appropriate, see 471 NAC 32-007.

To ensure a less institutional setting, each location where children are housed can serve no more than 2 units of up to 20 beds . Facilities may have up to two crisis intervention beds per unit (see 32-003 Treatment Crisis Intervention) and the facility must provide a home-like atmosphere.

32-006.03 Standards for Participation for Treatment Group Home Services

32-006.03A Provider Agreement: A provider of treatment group home services shall complete Form MC-19 or MC-20, "Medical Assistance Provider Agreement," and submit the completed form to the Department for approval. The Department is the sole determiner of which facilities are approved for participation in this program. The facility will be advised in writing when its participation is approved.

The provider shall submit the following with Form MC-19 or MC-20:

1. A written overview of the program's philosophy and objectives of treating children and youth including:
   a. A complete description of how the family-centered requirement will be met, including a complete description of any home-based family therapy services;
   b. A complete description of how the community-based requirement will be met;
   c. A description of each available service;
   d. A list of treatment modalities available and the capacity for individualized treatment planning;
   e. A statement of the qualification, education, and experience of each staff member providing treatment and the therapy service each provides;
   f. A schedule covering the total number of hours that the program operates;
   g. The Department approved cost reporting document; and
   h. The target population.
2. Facility/Program Changes: A treatment group home facility shall report to the HHS Resource Development and Support Unit and to the Division of Medicaid and Long-Term Care any major change in its program and/or facilities, before the change is made. The HHS Resource Development and Support Unit will determine whether the license must be modified or reissued. Any change in the capacity of a licensed facility requires that a license be reissued showing the number of youth who can be cared for under the new plan. The Division of Medicaid and Long-Term Care will determine if the facility maintains appropriate therapeutic programming for NMAP reimbursement.

3. Confirmation that the staffing standards in 471 NAC 32-006.03E are met.
4. Current licensure as a child caring agency. If the child caring agency license is denied or revoked, this requirement is not met; therefore, the provider is not eligible for participation.

32-006.03B Place of Service: Treatment group home services may be provided in the following locations when the requirements in this section have been met:

1. A community-based facility in operation prior to 7-1-94, as a treatment group facility. (These facilities may apply for an exception to the unit/bed maximum. The Department is the sole determiner of eligibility for this exception.)
2. A residential type community-based treatment facility appropriately licensed by the Nebraska Department of Health and Human Services, Division of Public Health; or
3. A hospital that is licensed as a hospital by the Nebraska Department of Health and Human Services, Division of Public Health, is accredited by the Joint Commission on Accreditation of Health-Care Organizations (JCAHO) or the American Osteopathic Association (AOA), meets the requirements for participation in Medicare, and has a utilization review plan applicable to all Medicaid clients in effect.

32-006.03B1 Facility and Program Requirements: In order to be approved as a provider of Treatment Group Home Services, the program must insure that the following requirements are met:

1. Adequate access to recreational facilities for both indoor and outdoor activities, commensurate with the size and scope of the program. (This may be provided on-site or through contract);
2. Separation of the treatment group home program from inpatient hospital operations, including laboratory, radiology, surgery, patient rooms, dining areas, patient lounges, etc.;
3. The doors to the unit and to the outside may be locked from the outside to allow for safety, but they must be unlocked or easily unlocked from the inside;
4. Kitchen and laundry facilities easily accessible to the unit;
5. Staff offices must be located on the unit;
6. Secure storage for medications and clinical charts must be on the unit;
7. A general living or lounge area must be on the unit;
8. A home-like atmosphere;
9. Program is staffed by awake personnel 24 hours per day; and
10. Other requirements as listed in this chapter.

32-006.03C Licensure: The treatment group home facility must -

1. Be in compliance with all applicable federal, state, and local laws;
2. Meet the program and operational definitions and criteria contained in the Nebraska Department of Health and Human Services Manual;
3. Meet the definition of a treatment group home facility as stated in this section;
4. Maintain documentation in each client's treatment record that provides a full and complete picture of the nature and quality of all services provided (see 471 NAC 32-006.07);
5. Have the capacity to meet the needs of the individual Medicaid client either through employment of or contracts with appropriate staff;
6. Be licensed under the minimum regulations for child caring agencies if not a hospital-based facility. If the child caring agency license is denied or revoked, this requirement is not met; therefore, the provider is not eligible for participation. (See 474 NAC 6-005, Licensing Group Homes and Child Caring and Placing Agencies.)

32-006.03D Accreditation: The licensed treatment group home must have -

1. Be accredited by JCAHO, CARF, COA or AOA; or
2. Include a copy of the accreditation certificate with the initial and updated enrollment materials and forward a copy of all survey visit reports and provider responses.

Facilities accredited by these accrediting bodies are eligible to receive reimbursement for treatment and maintenance (room and board) costs and must maintain accreditation in order to qualify as a treatment group home provider. Treatment and maintenance costs are reimbursed as a per diem rate. See NMAP Fee Schedule, (Appendix 471-000-532).

Interpretive Note: Agencies that have applied for accreditation may be enrolled on a provisional status and receive reimbursement for treatment services only.

32-006.03E Staffing Standards for Participation: A treatment group home for children shall meet the following standards to participate in NMAP:

1. The facility's staff must include -
   a. An executive director who has sufficient background and experience to administer a treatment program;
   b. A program director who meets the requirements of a clinical staff person in 471 NAC 32-001.04 and is acting within his/her scope of practice, with two years of professional experience in the treatment of children and adolescents with mental illnesses or emotional disturbances;
   c. Clinical staff professionals (who meet the requirements of a clinical staff person in 471 NAC 32-001.04) who provide family assessments and psychotherapy, including face-to-face individual, family, and group therapy, who are supervised by a licensed practitioner of the healing arts who is able to diagnose and treat major mental illness within his/her scope of practice;
   d. Child care staff who are age 21 or older and have specialized training and experience sufficient to equip them for their duties and are under the supervision of the program director. 67% of child care staff must have a bachelor's degree or four years of experience in the human services field;
   e. Supervisory staff will meet the standards outlined in 471 NAC 32-001.04 and have four years experience in a related field;
   f. Training must be approved by the Department and must meet the minimum standards for pre-service and on-going training in licensing requirements;
   g. A supervising practitioner who is a licensed practitioner of the healing arts who is able to diagnose and treat major mental illness within his/her scope of practice;
   h. Each facility shall show by employment records or on a contractual basis the ability to provide the needed services as indicated by the scope of the program, including necessary medical/psychiatric evaluations, and access to emergency care. The clinical services of a psychologist, psychiatrist, and physician may be obtained on a consultation basis; and
   i. Educators, when on-site education is provided. Services must be provided in accordance with applicable state and federal laws. NMAP does not make payment for educational services (see 471 NAC 32-006.05J);
2. Volunteer services may be used to augment and assist other staff in carrying out program or treatment plans. Volunteers who work directly with youth must receive orientation training regarding the program, staff, and children of the center and the functions that volunteers can perform. However, the services performed by a volunteer cannot be substituted for necessary medical/psychiatric and therapeutic patient/staff ratios;

3. Staff must be mentally and physically capable of performing assigned duties and demonstrate basic professional competencies as required by the job description. Every staff member shall have an annual physical examination and obtain a statement that no medical condition exists that may interfere with his/her ability to perform assigned duties. This is addressed in policy governing licensure regulations. All applicable state, federal, and local laws must be followed;
4. All program personnel having access to clients, including full-time, part-time, paid, volunteer, or contract, must be checked through the Central Registry, Adult Protective Services Registry, and the motor vehicle records. A criminal check must also be done through a law enforcement agency. A person whose name appears on any of the above registers because of behavior or activities that might be dangerous to clients must not have access to clients;
5. The ratio of professional staff to children is dependent on the needs of the children and commensurate with the size and scope of the program, however -
    a. The minimum ratio of Master's level therapists providing direct face-to-face therapy services to children and families must be 1:12;
    b. The supervising practitioner must be available to spend approximately 45 minutes per month or more often as clinically necessary, per client, in the facility as a minimum. This includes face-to-face time with the client, treatment plan reviews, and supervision;
    c. There must be sufficient supervising practitioner consultation hours on a regular basis to meet the requirements for active treatment. Youth at this level of care must be assessed by the supervising practitioner a minimum of once a month, or more frequently if medically necessary;
6. The ratio of child care staff to children during prime time hours is dependent on the needs of the children and the requirements of the individualized treatment plans. The ratio of staff to children must be commensurate with the size and scope of the program; however, minimum ratio is 1:6. This may be increased depending on the intensity of the program and the children's needs;
7. The ratio of child care awake staff during sleeping and non-prime hours is dependent on the needs of the children and must be commensurate with the size and scope of the program; however, the minimum ratio is 1:8. This may be increased depending on the intensity of the program and the individual child's needs.
8. The facility must be able to call back child care staff to provide staff and client safety in crisis situations.
9. If the facility has a level program that requires intense observation for admissions, the direct care staff to youth ratio will need to be more intense during that observation period.
10. Access to emergency services such as additional supervision and physician psychologist services must be available on a 24-hour basis.

32-006.03F Service Standards for Participation for Treatment Group Home Facilities: Treatment group home facilities shall -

1. Make every effort to keep the child in contact, where appropriate and possible, with the child's family and relatives, when reunification/reconciliation is the plan and maintain documentation of these activities;
2. Directly involve the immediate family in all phases of treatment and discharge planning. Family may include biological, step, foster, or adoptive parents, sibling or half sibling, and extended family members as appropriate. For wards of the Department, the case manager must be included in all phases of assessment, treatment planning, evaluation of services, and discharge/after care arrangements;
3. Provide a total of 21 hours of scheduled treatment interventions each week. These must include, but are not limited to:
   a. Group psychotherapy by a practitioner operating within their scope of practice;
   b. Individual therapy by a practitioner operating within their scope of practice;
   c. Family intervention (one hour per week minimum); and
   d. Other approved group or individual therapeutic activities.
4. Provide or arrange for face-to-face family therapy a minimum of twice a month. Depending on the child's needs, this may include reunification/reconciliation therapy and may also include biological, step, foster or adoptive families, psychological parents, and/or extended family (this is included in the 21 hours per week);
5. Provide the following mandatory services -
   a. Clinically Necessary Nursing Services: Medical services directed by a Qualified Registered Nurse who evaluates the particular medical nursing needs of each client and provides for the medical care and treatment that is indicated on the Department approved treatment planning document approved by the supervising practitioner.
   b. Clinically Necessary Psychological Diagnostic Services: Testing and evaluation services must reasonably be expected to contribute to the diagnosis and plan of care established for the individual client. Testing and evaluation services may be performed by a licensed psychologist acting within his/her scope of practice. Clinical necessity must be documented by the program supervising practitioner. Reimbursement for psychological diagnostic services is included in the per diem.
   c. Clinically Necessary Pharmaceutical Services: If medications are dispensed by the program, pharmacy services must be provided under the supervision of a registered pharmacy consultant; or the program may contract for these services through an outside licensed/certified facility. All medications must be stored in a special locked storage space and administered only by a physician, registered nurse, licensed practical nurse, or by a staff person approved by the Nebraska Department of Health and Human Services, Division of Public Health as a Medication Aide.

d. Clinically Necessary Dietary Services: The meal services provided must be supervised by a registered dietitian, based on the client's individualized diet needs. Programs may contract for these services through an outside licensed certified facility.
e. Transition and discharge planning must meet the requirements of 471 NAC 32-001.07A.

6. Optional Services: The program must provide two of the following optional services. The client must have a need for the services, the supervising practitioner must order the services, and the services must be a part of the client's treatment plan. The therapies must be restorative in nature, not prescribed for conditions that have plateaued or cannot be significantly improved by the therapy, or which would be considered maintenance therapy:
   a. Services provided or supervised by a licensed or certified therapist may be provided under the supervision of a qualified consultant or the program may contract for these services from a licensed/certified professional as listed below:
      (1) Recreational Therapy;
      (2) Speech Therapy;
      (3) Occupational Therapy;
      (4) Vocational Skills Therapy;
      (5) Self-Care Services: Services supervised by a staff person who is oriented toward activities of daily living and personal hygiene. This includes toileting, bathing, grooming, etc.
   b. Psychoeducational Services: Therapeutic psychoeducational services may be provided as part of a total program. Therapeutic psychoeducational services must be provided by teachers specially trained to work with child and adolescent experiencing mental health or substance abuse problems. These services may meet some strictly educational requirements, but must also include the therapeutic component. Professionals providing these services must be appropriately licensed and certified for the scope of practice.
   c. Social Work Services by a Bachelor's Level Social Worker: Case management social services to assist with personal, family, and adjustment problems which may interfere with effective use of treatment;
   d. Crisis Intervention (may be provided in the client's home);
   e. Social Skills Building;
   f. Life Survival Skills;
   g. Substance abuse prevention, intervention, or treatment by an appropriately licensed alcohol and drug counselor.

7. Provide appropriate conferences involving the client's interdisciplinary treatment team, the parents, the referring agency, and the child, to review the case status and progress at least every month. This does not substitute for documentation requirements. The need for conferences with interested parties is indicated by the individual child's circumstances and needs. For wards of the Department, this need will be jointly determined with the Department case manager;
8. Provide a multi-disciplinary team progress report to the referring agency , the parents, and the legal guardian every month for the purpose of service coordination. This progress report must include a summary of the work done, the progress made by each multi-disciplinary team area, since the last report; plus treatment plans for the next reporting period. For wards of the Department, monthly reports must be provided to the Division of Children and Family Services case manager. The documentation from the Monthly Treatment Plan review may serve this purpose.
9. The services of specialists in the fields of medicine, psychiatry, clinical psychology, and education must be used as needed. The costs of these services must be included in the total cost of care and cannot be billed separately.
10. Allow for more than one type of activity to be scheduled at one time allowing for specialized and individualized treatment planning.

32-006.03G Annual Update Renewal: The treatment group home shall submit the following information with the provider application and agreement, and update/renewal the information annually to coincide with submission of the cost report:

1. A written overview of the program's philosophy and objectives of treating children and youth including:
   a. A complete description of how the family-centered requirement will be met, including a complete description of any home-based family therapy services;
   b. A complete description of how the community-based requirement will be met;
   c. A description of each available service;
   d. A list of treatment modalities available and the capacity for individualized treatment planning;
   e. A statement of the qualification, education, and experience of each staff member providing treatment and the therapy service each provides;
   f. A schedule covering the total number of hours that the program operates;
   g. The cost report; and
   h. The target population.
2. Confirmation that the staffing standards are met;
3. A copy of child caring agency licensure certificate; and
4. A copy of accreditation from JCAHO, CARF, COA, or AOA.

The Division of Medicaid and Long-Term Care or its designee may request this information on an intermittent basis and the provider must comply by promptly supplying the requested information.

32-006.04 Covered Services: NMAP limits payment for treatment group home services to those services for medically necessary primary psychiatric diagnoses. NMAP covers treatment group home services when the services are medically necessary and provide active treatment.

32-006.04A Pre-Admission Authorization: For treatment group home services to be covered by NMAP, the admission must be recommended by a licensed practitioner of the healing arts who is able to diagnose and treat major mental illness within their scope of practice through a pre-treatment assessment as outlined in 471 NAC 32-001.01 and prior authorized through the Division of Medicaid and Long-Term Care or its designee. Consent for treatment for wards of the Department must be obtained from the case manager or supervisor.

32-006.04B Guidelines for Use of the Treatment Group Home Services for Children: A youth must have a diagnostic condition listed in the current diagnostic and statistics manual of the American Psychiatric Association (excluding V-codes and developmental disorders) for this level of care. NMAP applies the following general guidelines to determine when treatment group home services for children are clinically necessary for a client:

1. The child/youth requires 24-hour awake supervision;
2. Utilization of treatment group home care is appropriate for individualized treatment and is expected to improve the client's condition to facilitate moving the client to a less restrictive placement;
3. The child/youth's problem behaviors are persistent, may be unpredictable, and may jeopardize the health or safety of the client and/or others, but can be managed with this moderate level of structure;
4. The child/youth's daily functioning is moderately impaired in such areas as family relationships, education, daily living skills, community, health, etc.;
5. The child/youth has a history of previous problems due to ongoing inappropriate behaviors or psychiatric symptoms; or
6. Less restrictive treatment approaches have not been successful (see 42 CFR 441.152) or are deemed inappropriate by the supervising practitioner or treatment in a more restrictive setting has helped stabilize the client's behavior or psychiatric symptoms and they are ready to transition to a less restrictive level of care.

32-006.04C Therapeutic Passes for Clients Involved in Treatment Group Home Services: Therapeutic passes are an essential part of the treatment for client/families involved in treatment group home services. Documentation of the client's continued need for treatment group home services must follow overnight therapeutic passes. Therapeutic passes must be indicated in the treatment plan as they become appropriate. NMAP reimburses for only 60 therapeutic pass days per client per year. This includes all treatment services in which the client is involved during the year.

Therapeutic leave days are counted by the entity reimbursing for the care. Because the NMAP fee-for-service program reimburses for therapeutic leave days on a post-service basis and because providers have one year to bill for services, the Department cannot guarantee that an accurate account of the therapeutic leave days that have been used.

32-006.04D Vacations: If a treatment group home program takes the clients on a "vacation," NMAP will reimburse for those days under the following conditions -

1. The trip is prior authorized by the Division of Medicaid and Long-Term Care or its designee;
2. There is a clear statement of goals and objectives for the client's participation in the trip;
3. At least 50% of the scheduled treatment interventions must occur during the "vacation";
4. A clinical staff person must accompany the "vacation" trip; and
5. The "vacation" must be included in the treatment program.

NMAP will reimburse for up to seven "vacation" days per year for clients in treatment group home services.

32-006.05 Additional Requirements

32-006.05A Work Experience: When a treatment group home has a work program, it must -

1. Provide work experience that is appropriate to the developmental age and abilities of the child;
2. Differentiate between the chores that children are expected to perform as their share in the process of living together, specific work assignments available to children as a means of earning money, and jobs performed in or out of the center to gain vocational training;
3. Give children some choice in their work experiences and offer change from routine duties to provide a variety of experiences;
4. Not interfere with the child's time for school, study periods, play, chores, sleep, normal community activities, visits with the child's family, or individual, group, or family therapy;
   Clients may not be solely responsible for any major phase of the center's operation or maintenance, such as cooking, laundering, housekeeping, farming, or repairing;
5. Comply with all state and federal labor laws.

32-006.05B Solicitation of Funds: A treatment group home may not use a child for advertising, soliciting funds, or in any way that may cause harm or embarrassment to the child or the child's family. Written consent of the parent or guardian must be obtained before the treatment group home uses a child's picture, person, or name in any form of written, visual, or verbal communication. Before obtaining consent, the treatment group home shall advise the parent or guardian of the purpose for which it intends to use the child's picture, person, or name, and of the times and places when and where this use would occur. Photos of the Department state wards cannot be used for these purposes.

32-006.05C Special Treatment Procedures: Special treatment procedures in treatment group homes are limited to physical restraint. Locked time out (LTO), mechanical restraints, and pressure point tactics are not allowed. For wards of the Department, the case manager must approve use of physical restraints and must be informed within 24 hours each time they are used. Guardians and parents of non-wards must give informed consent and be informed of the use of physical restraints.

Facilities must meet the following standards regarding physical restraints:

1. De-escalation techniques must be taught to staff and used appropriately before the initiation of physical restraints;
2. Physical restraints may be used only when a youth's behavior presents a danger to self or others, or to prevent serious disruption to the therapeutic environment; and
3. The youth's treatment plan must address the use of physical restraints and have a clear plan to decrease the behavior requiring physical restraints.

These standards must be reflected in all aspects of the treatment program. Attempts to de-escalate, the use of restraints, and subsequent processing must be documented in the clinical record.

32-006.05D Medical Care: The center shall ensure that the following medical care is provided for each child:

1. Each child must receive a medical examination immediately before or at the time of admission;
2. Each child must have current immunizations as required by the Nebraska Department of Health and Human Services;
3. The treatment group home shall arrange with a physician and a psychiatrist for the medical and psychiatric care of the clients;
4. Each child must have a medical examination/HEALTH CHECK (EPSDT) screen annually as allowed in 471 NAC 33-000 ff.;
5. The treatment group home shall inform staff members of what medical care, including first aid, may be given by staff without specific physician orders. Staff must be instructed on how to obtain further medical care and how to handle emergency cases. The center shall ensure that -
    a. Staff members on duty must have satisfactorily completed current first aid and cardiopulmonary resuscitation training and have on file at the treatment group home a certificate of satisfactory completion as required by licensure regulations of the Department of Health and Human Services, Division of Public Health;
    b. Each staff member must be able to recognize the common symptoms of illnesses in children and to note any marked physical defects of children; and
    c. A sterile clinical thermometer, a complete first aid kit, and clearly posted emergency phone numbers must be available, according to licensure regulations of the Department of Health and Human Services.

32-006.05E Hospital Admissions: The treatment group home shall make arrangements for the emergency admission of children from the center in case of serious illness, emergency, or psychiatric crisis. For wards of the Department, the case manager or the case manager's supervisor must give permission for admission.

In the event that a client does require hospitalization while in a treatment group home, NMAP will reimburse the treatment program for up to 15 days per hospitalization. This reimbursement is only available if the treatment placement is not used by another client.

32-006.05F Hospitalization or Death Reports: The treatment group home shall report any accident or illness requiring hospitalization to the parents or guardian immediately. The treatment group home shall immediately report any death to the parents or guardian, the Department, a law enforcement agency, and the county coroner. If the child is a Department ward, see 390 NAC 11-002.01D.

32-006.05G Dental Care: Each child must have an annual dental examination. If a child has not had a dental exam in the twelve months before admission, an examination must occur within 90 days following admission. See 471 NAC 6-000 and 33-000 and 474 NAC 6-005.26F.

32-006.05H General Health: The treatment group home shall ensure the following:

1. Each child must have enough sleep for the child's age and physical and emotional condition at regular and reasonable hours, and under conditions conducive to rest. While children are asleep, at least one staff member must be within hearing distance;
2. Children must be encouraged and helped to keep themselves clean;
3. Bathing and toilet facilities must be properly maintained and kept clean;
4. Each child must have a toothbrush, comb, an adequate supply of towels and washcloths, and personal toilet articles;
5. Menus must provide for a varied diet that meets a child's daily nutritional requirements;
6. Each child must have clothing for the child's exclusive use. The clothing must be comfortable and appropriate for the current weather conditions; and
7. The treatment group home must provide safe, age-appropriate equipment for indoor and outdoor play.

See 471 NAC 33-000.

32-006.05J Education: Educational services, when required by law, must be available. Education services must only be one aspect of the treatment plan, not the primary reason for admission or treatment. Educational services are not eligible for payment by the Department.

32-006.05K Religious Education: Children must be provided with an opportunity to receive instruction in their religion. No child may be required to attend religious services or to receive religious instructions if the child chooses not to attend the services or receive instruction.

32-006.05L Discipline: Discipline must be therapeutic and remedial rather than punitive. Corporal punishment, verbal abuse, and derogatory remarks about the child, the child's family, religion, or cultural background are prohibited. A child may not be slapped, punched, spanked, shaken, pinched, or struck with an object by any staff of the center. Only staff members of the treatment group home may discipline children (see 474 NAC 6-005.26K).

32-006.05M Transition and Discharge Planning: Whenever a child or adolescent is transferred from one setting to another, transition and discharge planning must be performed and be documented, beginning at the time of admission (see 471 NAC 32-001.07A and 474 NAC 6-005.27H).

Facilities must meet the following standards regarding transition and discharge planning:

1. Transition and discharge planning must be based on the multidisciplinary treatment plan designed to achieve the client's transition into and discharge from treatment group home treatment status to a less restrictive level of care at the earliest possible time;
2. Transition and discharge planning must address the client's need for ongoing treatment to maintain treatment gains, continuing education and support for normal physical and mental development following discharge;
3. Discharge planning must include identification of and clear transition into developmentally appropriate services needed following discharge;
4. The treatment group home treatment facility shall arrange for prompt transfer of appropriate records and information to ensure continuity of care during transition into and following the client's discharge;
5. A written transition and discharge summary must be provided as part of the medical record; and
6. The child's parents (and the caseworker if the child is a ward) must be included in all phases of transition and discharge planning. This participation must be clearly documented in the client's record.

32-006.05N Notification of Runaway Children: See 390 NAC 7-001.05.

32-006.05P Interstate Compact on the Placement of Children: The center shall comply with the interstate compact on the placement of children. (See 474 NAC 6-005.)

32-006.05Q Medications: The treatment group home may possess a limited quantity of nonprescription medications and administer them under the supervision of designated staff. The treatment group home must follow all applicable regulations through the Department of Health and Human Services, Division of Public Health for storing and administering medications.

The treatment group home shall have written policies governing the use of psychotropic medications. Parents and the guardian of a client who receives psychotropic medication must be informed of the benefits, risks, side effects, and potential effects of medications. A parent and legal guardian's written informed consent for use of the medication must be obtained before giving the medication and filed in the client's record. If the client is a state ward, informed consent must be given by the Department case manager.

A child's medication regime must be reviewed by the prescribing physician at least every seven days for the first 30 days following the initiation of a new medication and at least every 30 days thereafter.

32-006.06 Individualized Treatment: The requirements of 42 CFR 441, Subpart D, must be met. To be covered by NMAP, services must include -

1. Program philosophy: Treatment Group Home facilities must provide family-centered, community-based, developmentally appropriate services under the direction of a supervising practitioner.
   a. These services must be able to meet the special needs of families with emotionally disturbed children. Families must be involved in all phases of treatment and discharge planning. For wards of the Department, the Department case manager must also be involved in all phases of treatment and discharge planning.
   b. The program intensity must be such that direct care staff, the youth in treatment, and/or the youth's family have access to professional staff on an "as needed" basis, determined by the child's condition.

2. Active treatment, which must be -
   a. Treatment provided under a multi-disciplinary treatment plan reviewed and approved by the supervising practitioner. This plan will be developed by a multi-disciplinary team of professional staff members. The treatment plan must be for a primary psychiatric diagnosis and must be based on a thorough evaluation of the client's restorative needs and the client's potential. The initial treatment plan must be developed within 14 days of the client's admission. The treatment plan must be reviewed at least every 30 days by the multi-disciplinary team, the parents and/or the parents' advocate, the referring agency and the child.

      The goals and objectives documented on the treatment plan must reflect the recommendations included in the Pre-treatment Assessment and the integration of input from the supervising practitioner and the therapist. The treatment interventions provided must reflect these recommendations, goals, and objectives. Evaluation of the treatment plan by the therapist and the supervising practitioner should reflect the client's response to the treatment interventions based on the recommendations, goals and objectives.
   b. In compliance with 471 NAC 32-001.07, Treatment Planning; and
   c. In compliance with 471 NAC 32-001.06, Active Treatment.
3. Medically necessary services, which must be an appropriate level of care based on the documented pre-treatment assessment (see 471 NAC 32-001.01) including an Initial diagnostic interview by the supervising practitioner either prior to admission or immediately following admission.

32-006.07 Documentation in the Client's Clinical Record: The treatment group home must maintain accurate records indicating the degree and intensity of the treatment provided to clients who receive services in the treatment group home facility. For treatment group home services, clinical records must stress the clinical components of the care, including history of findings and treatment provided for the condition for which the client is in the facility. The record must include the requirements stated in 471 NAC 32-001.05, and -

1. The identification data, including the client's legal status (i.e., voluntary admission, Board of Mental Health commitment, court mandated);
2. A provisional or admitting diagnosis which is determined for every patient at the time of admission and includes the diagnoses of intercurrent diseases as well as the diagnoses;
3. The statements of others regarding the client's problems and needs, as well as the client's statement of their problems and needs;
4. The pre-treatment assessment (see 471 NAC 32-001.01), including a medical/psychiatric history, which contains a record of the initial diagnostic interview and notes the onset of illness, the circumstances leading to admission, attitudes, behavior, estimate of intellectual functioning, memory functioning, orientation, and an inventory of the client's strengths in a descriptive, not interpretative, fashion;
5. Complete psychological evaluation when indicated;
6. Complete neurological examination, when indicated;

7. A social history sufficient to provide data on the client's relevant past history, present situation, social support system, community resource contacts, and other information relevant to good treatment, and transition and discharge planning.
8. A thorough family assessment;
9. Reports of consultations, electroencephalograms, dental records, and special studies;
10. The treatment received by the client, which is documented in a manner and with a frequency to ensure that all active therapeutic efforts, such as individual, group, and family psychotherapy, drug therapy, milieu therapy, occupational therapy, recreational therapy, nursing care, and other therapeutic interventions, are included;
11. Progress notes must be recorded by all professional staff and, when appropriate, others significantly involved in active treatment modalities, following each contact. The frequency is determined by the individual treatment plan and the condition of the client. Progress notes must contain a concise assessment of the client's progress and recommendations for revising the treatment plan as indicated by the client's condition. Child care workers must maintain 24-hour documentation of a client's whereabouts and activities.
12. The transition plan and discharge summary, including a summary of the client's and family's treatment, recommendations for appropriate services concerning follow-up, and a brief summary of the client's condition on discharge.
13. The psychiatric diagnosis contained in the final diagnosis written in the terminology of the American Psychiatric Association's Diagnostic and Statistical Manual; and
14. The client's response to therapeutic leave days recommended by the supervising practitioner under the treatment plan. The client's, family's, or guardian's response to time spent outside the facility must be entered in the client's clinical record.

All documents from the client's clinical record submitted to the Department must contain sufficient information for identification (i.e., client's name, date of service, provider's name).

32-006.08 Utilization Review: All facilities must provide utilization review.

32-006.09 Documentation for Claims: The following documentation is required for all claims for treatment group home services. This requirement may be waived at the Department's discretion. The facility will be notified in writing if that occurs:

1. Pre-treatment assessment (biopsychosocial assessment and initial diagnostic interview);
2. The treatment plan;
3. Orders by the supervising practitioner; and
4. Progress notes for all disciplines.

All claims are subject to utilization review by the Department prior to payment.

32-006.09A Exception: Additional documentation from the client's clinical record may be requested by the Department prior to considering authorization of payment.

32-006.10 Procedure Code and Description for Treatment Group Home Services: HCPCS/CPT codes used by NMAP are listed in the Nebraska Medicaid Practitioner Fee Schedule at 471-000-532.

32-006.11 Costs Not Included in the Treatment Group Home Per Diem: The mandatory and optional services are considered to be part of the per diem for treatment services. The following charges can be reimbursed separately from the treatment group home per diem when the services are necessary, part of the client's overall treatment plan, and in compliance with NMAP policy:

1. Direct client services performed by the supervising practitioner;
2. Prescription medications (including injectable medications);
3. Direct client services performed by a physician other than the supervising practitioner; and
4. Treatment services for a physical injury or illness provided by other professionals.

If the client is enrolled with another managed care vendor for medical-surgical services, it may be necessary to pursue prior authorization or referral with that entity.

32-006.12 Inspections of Care: The Department's inspection of care team may conduct inspection of care reviews for Treatment Group Home Services. See 471 NAC 32-001.08 and 471 NAC 32-001.09.

32-007 Residential Treatment Services for Children/Adolescents

32-007.01 Introduction: Residential treatment services are available to clients age 20 or younger when the client participates in a HEALTH CHECK (EPSDT) screen, the treatment is clinically necessary, and the need for care at this level has been identified on the pre-treatment assessment (see 471 NAC 32-001.01).

Residential treatment services must be family-centered, culturally competent, community based, and developmentally appropriate.

Providers must encourage family members to be involved in the assessment of the client, the development of the treatment plan, and all aspects of the client's treatment unless prohibited by the client, through legal action, or because of federal confidentiality laws.

Providers must be available to schedule meetings and sessions in a flexible manner to accommodate and work with a family's schedule. This includes the ability to schedule sessions at a variety of times including weekends or evenings.

The provider must document their attempts to involve the family in treatment plan development and treatment plan reviews. A variety of communication means should be considered. These may include, but should not be limited to, including the family via conference telephone calls, using registered letters to notify the family of meetings, and scheduling meetings in the evening and on weekends.

Residential treatment services for children covered by NMAP include residential treatment for children age 20 and younger who are eligible for Medicaid. These regulations also cover children age 18 or younger who are wards of the Department.

Residential treatment services must be provided under the direction of a supervising practitioner as designated in 471 NAC 32-001.02A.

32-007.02 Residential Treatment for Children: The Department's philosophy is that all care provided to clients must be provided at the least restrictive and most appropriate level of care. Care must be family-centered, community-based, culturally competent, and developmentally appropriate. NMAP will cover more restrictive levels of care only when all other resources have been explored and deemed to be inappropriate. If hospital-based inpatient care is deemed appropriate, see 471 NAC 32-008.

Residential treatment center services are clinically necessary services provided to a client who requires professional care and highly structured 24-hour awake care at a greater intensity than that available at the treatment group home and foster home levels.

In keeping with the philosophy that children are better served in more family-like settings, the total number of approved beds for a residential treatment center will not exceed two units of up to 20 beds each, and the center must provide a home-like atmosphere commensurate with the size and scope of the program. Exception: A state owned and operated residential treatment center may exceed two units provided that each unit has no more than 20 beds each. When a state owned and operated residential treatment center exceeds two 20 bed units, children may be placed there for treatment only if all other in state residential treatment center providers have declined to serve the child within a reasonable period of time. This exception shall expire two years after the effective date of the exception.

32-007.03 Standards for Participation for Residential Treatment Centers

32-007.03A Provider Agreement: A provider of residential treatment center services shall complete Form MC-19 or Form MC-20, "Medical Assistance Provider Agreement," and submit the completed form to the Department for approval. The Department is the sole determiner of which centers are approved for participation in this program. The facility will be advised in writing when its participation is approved.

The provider shall submit the following with Form MC-19 or Form MC-20:

1. A written overview of the program's philosophy and objectives of treating children and youth including:
   a. A description of each available service;
   b. A list of treatment modalities available and the capacity for individualized treatment planning;
   c. A statement of the qualification, education, and experience of each staff member providing treatment and the therapy service each provides;
   d. A schedule covering the total number of hours that the program operates;
   e. The Department approved cost reporting document; and
   f. The target population.
2. Facility/Program Changes: A residential treatment facility shall report to the HHS Licensing Unit and to the Division of Medicaid and Long-Term Care any major changes in its program and/or facilities, before the change is made. The HHS Licensing Unit will determine whether the license must be modified or reissued. Any change in the capacity of a licensed facility requires that a license be reissued showing the number of youth who can be cared for under the new plan. The Division of Medicaid and Long-Term Care will determine if the facility maintains appropriate therapeutic programming for NMAP.
3. Confirmation that the staffing standards in 471 NAC 32-007.04D are met.
4. Current licensure as a child caring agency. If the child caring agency license is denied or revoked, this requirement is not met; therefore, the provider is not eligible for participation. Licensure as a child caring agency is not required for hospital-based services.
5. Copy of JCAHO, CARF, AOA, or COA accreditation certificate.

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3. Confirmation that the staffing standards in 471 NAC 32-007.04D are met.
4. Current licensure as a child caring agency. If the child caring agency license is denied or revoked, this requirement is not met; therefore, the provider is not eligible for participation. Licensure as a child caring agency is not required for hospital-based services.
5. Copy of JCAHO, CARF, AOA, or COA accreditation certificate.

32-007.03B Place of Service: Residential treatment services may be provided in the following locations when the requirements listed in 471 NAC 32-007.04B have been met:

1. A residential type community-based treatment facility appropriately licensed by the Nebraska Department of Health and Human Services, Division of Public Health; or
2. A hospital that is licensed as a hospital by the Nebraska Department of Health and Human Services, Division of Public Health, is accredited by the Joint Commission on Accreditation of Health-Care Organizations (JCAHO) or the American Osteopathic Association (AOA), meets the requirements for participation in Medicare, and has a utilization review plan applicable to all Medicaid clients in effect.

32-007.03B1 Facility Requirements: In order to be approved as a provider of Residential Treatment Services, the program must insure that the following requirements are met:

1. Adequate access to recreational facilities for both indoor and outdoor activities, commensurate with the size and scope of the program. (This may be provided on-site or through contract);
2. Separation of the treatment group home program from inpatient hospital operations, including laboratory, radiology, surgery, patient rooms, dining areas, patient lounges, etc.;
3. The doors to the unit and to the outside may be locked from the outside to allow for safety, but they must be unlocked or easily unlocked from the inside;
4. Kitchen and laundry facilities easily accessible to the unit;
5. Staff offices must be located on the unit;
6. Secure storage for medications and clinical charts must be on the unit;
7. A general living or lounge area must be on the unit;
8. A home-like atmosphere;
9. Program is staffed by awake personnel 24 hours per day; and
10. Other requirements as listed in this chapter.

32-007.03C Other Requirements: The residential treatment center must -

1. Be in conformance with all applicable federal, state, and local laws;
2. Meet the program and operational definitions and criteria contained in the Nebraska HHS Finance and Support Manual;
3. Meet the definition of a residential treatment center as stated in 471 NAC 32-007.02;

4. Maintain documentation in each client's treatment record that provides a full and complete picture of the nature and quality of all services provided (see 471 NAC 32-007.07);
5. Have the capacity to meet the needs of the individual Medicaid client either through employment of or contracts with appropriate staff (see 471 NAC 32-007.04D);
6. Be licensed by the Department under the minimum regulations for child caring agencies. If the child caring agency license is denied or revoked, this requirement is not met; therefore, the provider is not eligible for participation (See 474 NAC 6-005, Licensing Group Homes and Child Caring and Placing Agencies and Nebraska State Statute 81-505.01, 1983.) Hospitals are not required to be licensed as a child caring agency.

32-007.03D Accreditation: The residential treatment center must have -

1. Be accredited by JCAHO, CARF, COA or AOA; or
2. Include a copy of the accreditation certificate with the initial and updated enrollment materials and forward a copy of all survey visit reports and provider responses.

If the most recent survey required a plan of corrections, the plan must also be submitted; or

Agencies accredited through these accrediting bodies are eligible for NMAP reimbursement of treatment and maintenance (room and board) costs and must maintain accreditation in order to qualify as a residential treatment services provider. Treatment and maintenance costs are reimbursed as a per diem rate. See NMAP Fee Schedule, (Appendix 471-000-532).

Interpretive Note: Agencies that have applied for accreditation with one of these entities may be enrolled on a provisional status and receive reimbursement for treatment only.

32-007.03E Staffing Standards for Participation: A residential treatment center for children shall meet the following standards to participate in NMAP:

1. The center's staff must include -
   a. An executive director who has a sufficient background and experience to administered a treatment program;
   b. A program director who meets the requirements of a clinical staff person in 471 NAC 32-001.04 and is operating within his/her scope of practice, with two years of professional experience in the treatment of children and adolescents with mental illnesses or emotional disturbances;
   c. Clinical staff professionals (who meet the requirements of a clinical staff person in 471 NAC 32-001.04) who provide psychotherapy and counseling, including face-to-face individual, family, and group counseling, who are directed by the supervising practitioner;

d. Child care staff who are age 21 or older and have specialized training and experience sufficient to equip them for their duties and are under the supervision of the program director. 75% of child care staff must have a bachelor's degree or five years of experience in human services field;
e. Supervisory staff will meet the standards outlined in 471 NAC 32-001.04 and four years experience in a related field.
f. Training must be approved by the Department and must meet the minimum standards for pre-service and on-going training in licensing requirements;
g. A supervising practitioner who is a licensed psychologist, physician, or doctor or osteopathy;
h. Each facility shall show by employment records or on a contractual basis the ability to provide the needed services as indicated by the scope of the program, including necessary medical/psychiatric evaluations, and access to emergency care. The clinical services of a psychologist, psychiatrist, and physician may be obtained on a consultation basis; and
j. Educators, when on-site education is provided. Services must be provided in accordance with applicable state and federal laws. NMAP does not make payment for educational services;

2. Volunteer services may be used to augment and assist other staff in carrying out program or treatment plans. Volunteers who work directly with youth must receive orientation training regarding the program, staff, and children of the center and the functions that volunteers can perform. However, the services performed by a volunteer cannot be substituted for necessary medical/psychiatric and therapeutic patient/staff ratios;
3. Staff must be mentally and physically capable of performing assigned duties and demonstrate basic professional competencies as required by the job description. Every staff member shall have an annual physical examination and obtain a statement that no medical condition exists that may interfere with his/her ability to perform assigned duties. This is addressed in policy governing licensure regulations. All applicable state, federal, and local laws must be followed.
4. All program personnel having access to clients, including full-time, part-time, paid, volunteer or contract, must be checked through the Central Registry, Adult Protective Services Registry, and the motor vehicle records. A criminal check must also be done through a law enforcement agency. A person whose name appears on any of the above registries must not have access to clients.

5. The ratio of professional staff to children is dependent on the needs of the children and commensurate with the size and scope of the program, however -
   a. The minimum ratio of Master's level therapists providing direct face-to-face therapy services to children and families must be 1:10;
   b. The supervising practitioner must be available to spend approximately 45 minutes (or more often as clinically necessary) per month, per client, in the facility as a minimum. This includes face-to-face time with the client, treatment plan reviews, and supervision;
   c. There must be sufficient supervising practitioner consultation hours on a regular basis to meet the requirements for active treatment (see 471 NAC 32-007.06) and to properly supervise the Master's level therapists (see 471 NAC 32-007.03F). Youth at this level of care must be seen and interviewed by the supervising practitioner a minimum of once every 30 days.
6. The ratio of child care staff to children during prime time hours is dependent on the needs of the children and the requirements of the individualized treatment plans. The ratio of staff to children must be commensurate with the size and scope of the program; however, minimum ratio is 1:4. This may be increased depending on the intensity of the program and the child's needs.
7. The ratio of child care awake staff during sleeping and non-prime hours is dependent on the needs of the children and must be commensurate with the size and scope of the program; however, the minimum ratio is 1:6. This may be increased depending on the intensity of the program and the individual child's needs.
8. The facility must be able to call back child care staff to provide staff and client safety in crisis situations.
9. If the facility has a level program that requires intense observation for admissions, the direct care staff to youth ratio will need to be more intense during that observation period.
10. Access to emergency services such as additional supervision and medical/psychiatric care must be available on a 24-hour basis.
11. Those facilities providing this service prior to the effective date of this policy may apply to become an approved provider with their current staffing levels provided:
    a. Any new staff hired must meet the criteria stated in these policies; and
    b. Staff ratios are upgraded to policy standards within four months of the policy's effective date.

32-007.03F Service Standards for Participation for Residential Treatment Centers: Residential treatment centers shall -

1. Make every effort to keep the child in contact, when appropriate and possible, with the child's family and relatives, when reunification or reconciliation is the plan;
2. Involve the parents and family, when appropriate and possible, in the treatment planning. For wards of the Department, the case manager must be included in all phases of assessment, treatment planning, evaluation of services, and discharge/after care arrangements;
3. Provide a minimum of 42 hours of scheduled treatment intervention per week. These include, but are not limited to:
   a. Group psychotherapy by a practitioner operating within his/her scope of practice;
   b. Individual therapy by a practitioner operating within his/her scope of practice;
   c. Family intervention (one hour per week minimum);
   d. Face-to-face sessions with the supervising practitioner; and
   e. Other approved group or individual therapeutic activities.
4. Provide or arrange for face-to-face family therapy a minimum of twice a month. Depending on the child's needs, this may include reunification/reconciliation therapy and may also include biological families, foster families, adoptive families, and/or extended family;
5. Provide the following mandatory services -
   a. Clinically Necessary Nursing Services: Medical services directed by a Qualified Registered Nurse who evaluates the particular nursing needs of each client and provides for the medical care and treatment that is indicated on the Department approved treatment planning document approved by the supervising practitioner. Reimbursement for psychological diagnostic services is included in the per diem.
   b. Clinically Necessary Psychological Diagnostic Services: Testing and evaluation services must reasonably be expected to contribute to the diagnosis and plan of care established for the individual client. Testing and evaluation services may be performed by a Clinical Psychologist acting within his/her scope of practice. Clinical necessity must be documented by the program supervising practitioner.
   c. Clinically Necessary Pharmaceutical Services: If medications are dispensed by the program, pharmacy services must be provided under the supervision of a registered pharmacy consultant; or the program may contract for these services through an outside licensed/certified facility. All medications must be stored in a special locked storage space and administered only by a physician, registered nurse, licensed practical nurse, or a staff person approved by the Nebraska Department of Health and Human Services, Division of Public Health as a Medication Aide.

d. Clinically Necessary Dietary Services: The meal services provided must be supervised by a registered dietitian, based on the client's individualized diet needs. Programs may contract for these services through an outside licensed certified facility.
e. Transition and discharge planning must meet the requirements of 471 NAC 32-001.07A.

6. Optional Services: The program must provide two of the following optional services. The client must have a need for the services, the supervising practitioner must order the services, and the services must be a part of the client's treatment plan. The therapies must be restorative in nature, not prescribed for conditions that have plateaued or cannot be significantly improved by the therapy, or which would be considered maintenance therapy:
   a. Services provided or supervised by a licensed or certified therapist may be provided under the supervision of a qualified consultant or the program may contract for these services from a licensed/certified professional as listed below:
      (1) Recreational Therapy;
      (2) Speech Therapy;
      (3) Occupational Therapy;
      (4) Vocational Skills Therapy;
      (5) Self-Care Services: Services supervised by a registered nurse or occupational therapist who is oriented toward activities of daily living and personal hygiene. This includes toileting, bathing, grooming, etc.
   b. Psychoeducational Services: Therapeutic psychoeducational services may be provided as part of a total program. Therapeutic psychoeducational services must be provided by teachers specially trained to work with child and adolescents experiencing mental health or substance abuse problems. These services may meet some strictly educational requirements, but must also include the therapeutic component. Professionals providing these services must be appropriately licensed and certified for the scope of practice.
   c. Social Work Services by a Bachelor's Level Social Worker: Social services to assist with personal, family, and adjustment problems which may interfere with effective use of treatment, i.e., case management type services.
   d. Crisis Intervention (may be provided in home);
   e. Social Skills Building;
   f. Life Survival Skills;
   g. Substance abuse prevention, intervention, or treatment by an appropriately licensed alcohol and drug counselor.

7. Provide appropriate conferences involving the youth's interdisciplinary treatment team, the parents, the referring agency, and the child, to review the case status and progress at least every month. This does not substitute for documentation requirements. The need for conferences with interested parties is indicated by the individual child's circumstances and needs, which may indicate conferences occurring more frequently. For wards of the Department, this need will be jointly determined with the case manager;

8. Allow for more than one type of activity to be scheduled at one time allowing for specialized and individualized treatment planning;
9. Provide a progress report to the referring agency, and the parents or legal guardian every month for the purpose of service coordination. For wards of the Department, monthly reports must be provided to the Division of Children and Family Services case manager. The documentation from the Monthly Treatment Plan review may serve this purpose;
10. The services of specialists in the fields of medicine, psychiatry, psychology, and education must be used as needed.

32-007.03G Annual Update/Renewal: The residential treatment center shall submit the following information with the provider application and agreement, and update/renewal the information annually to coincide with submission of the cost report:

1. A written overview of the program's philosophy and objectives of treating children and adolescents including:
   a. A description of each available service;
   b. A list of treatment modalities available and the capacity for individualized treatment planning;
   c. A statement of the qualification, education, and experience of each staff member providing treatment and the therapy service each provides;
   d. A schedule covering the total number of hours that the program operates;
   e. The cost report; and
   f. The target population.
2. Confirmation that the staffing standards in 471 NAC 32-007.03E are met;
3. Copy of child caring agency licensure certificate; and
4. Copy of accreditation certificate.

The Division of Medicaid and Long-Term Care or its designee may request this information on an intermittent basis and the provider must comply by promptly supplying the requested information.

32-007.04 Covered Services: NMAP limits payment for residential treatment services to those services for medically necessary to treat primary diagnoses. NMAP covers residential services as delineated in 471 NAC 32-007 when the services are medically necessary and provide active treatment.

32-007.04A Pre-Admission Authorization: For residential treatment center services to be covered by NMAP, the need for admission to this level of care must be determined by a supervising practitioner through a thorough pre-treatment assessment (see 471 NAC 32-001.01) and prior authorized through the Medicaid Division or its designee. For wards of the Department, consent for treatment for wards of the Department must be obtained from the Department case manager or supervisor. See 471 NAC 32-001.

32-007.04B Guidelines for Use of Residential Treatment Services for Children: A youth must have a diagnosable condition listed in the current diagnostic and statistics manual of the American Psychiatric Association (excluding V-codes and developmental disorders) for this level of care. NMAP applies the following guidelines to determine when residential treatment services for children or adolescents are medically necessary for a client:

1. The child/adolescent requires 24-hour awake supervision with high staff ratios;
2. Utilization of residential treatment services is appropriate for individualized treatment and is expected to improve the client's condition to facilitate moving the client to a less restrictive placement;
3. The child/adolescent's problem behaviors are persistent, unpredictable, and may jeopardize the health or safety of the client and/or others;
4. The child/adolescent's daily functioning must be significantly impaired in multiple areas, such as family relationships, education, daily living skills, community, health, etc.;
5. The child/adolescent has a documented history of previous placement disruptions due to on-going behaviors/psychiatric issues; and
6. Less restrictive treatment approaches have not been successful or are deemed inappropriate by the referring supervising practitioner.

32-007.04C Therapeutic Passes for Clients Involved in Residential Treatment Services: Therapeutic passes are an essential part of the treatment for client/families involved in residential treatment services. Documentation of the client's continued need for residential treatment services must follow overnight therapeutic passes. Therapeutic passes must be indicated in the treatment plan as they become appropriate. NMAP reimburses for only 60 therapeutic pass days per client per year. This includes all treatment services in which the client is involved during the year.

Therapeutic leave days are counted by the entity reimbursing for the care. Because the NMAP fee-for-service program reimburses for therapeutic leave days on a post-service basis and because providers have one year to bill for services, the Department cannot guarantee that an accurate account of the therapeutic leave days that have been used.

32-007.04D Vacations: If a residential treatment program takes the clients on a "vacation," NMAP will reimburse for those days under the following conditions -

1. The trip is prior authorized by the Division of Medicaid and Long-Term Care or its designee;
2. There is a clear statement of goals and objectives for the individual client's participation in the trip;
3. At least 50% of the scheduled treatment interventions must occur during the "vacation";
4. A clinical staff person must accompany the "vacation" trip; and
5. The "vacation" must be included in the treatment program.

NMAP will reimburse for up to seven "vacation" days per year for clients in residential treatment program.

32-007.05 Additional Requirements

32-007.05A Work Experience: When a center has a work program, it must -

1. Provide work experience that is appropriate to the developmental age and abilities of the child/adolescent;
2. Differentiate between the chores that children/adolescents are expected to perform as their share in the process of living together, specific work assignments available to children/adolescents as a means of earning money, and jobs performed in or out of the center to gain vocational training;
3. Give children/adolescents some choice in their work experience and offer change from routine duties to provide a variety of experiences;
4. Not interfere with the child/adolescent's time for school, study periods, play, chores, sleep, normal community activities, visits with the family, or individual, group, or family therapy.
5. Children/adolescents may not be solely responsible for any major phase of the center's operation or maintenance, such as cooking, laundering, housekeeping, farming, or repairing; and
6. Comply with all state and federal labor laws.

32-007.05B Solicitation of Funds: A center may not use a child/adolescent for advertising, soliciting funds, or in any other way that may cause harm or embarrassment to the child/adolescent or the family. Written consent of the parent or guardian must be obtained before the center uses a child's picture, person, or name in any form of written, visual, or verbal communication . Before obtaining consent, the center shall advise the parent or guardian of the purpose for which it intends to use the child's picture, person, or name, and of the times and places when and where this use would occur.

32-007.05C Special Treatment Procedures: If a youth needs behavior management and containment beyond unlocked time outs or redirection, special treatment procedures may be utilized. Special treatment procedures in psychiatric RTC's are limited to physical restraint, locked time out (LTO), and a locked unit. Mechanical restraints and pressure point tactics are not allowed. Parents or legal guardians or the Department case manager must approve use of these procedures through informed consent and must be informed within 24 hours each time they are used.

Facilities must meet the following standards regarding special treatment procedures:

1. De-escalation techniques must be taught to staff and used appropriately before the initiation of special treatment procedures;
2. Special treatment procedures may be used only when a child/adolescent's behavior presents a danger to self or others, or to prevent serious disruption to the therapeutic environment; and
3. The child/adolescent's treatment plan must address the use of special treatment procedures and have a clear plan to decrease the behavior requiring LTO, physical restraints, or a locked unit.

These standards must be reflected in all aspects of the treatment program. Attempts to de-escalate, the special treatment procedure and subsequent processing must be documented in the clinical record and reviewed by the supervising practitioner.

32-007.05D Medical Care: The center shall ensure that the following medical care is provided for each child/adolescent:

1. Each child/adolescent must receive a medical examination (EPSDT/Health Check exam) before or at the time of admission;
2. Each child/adolescent must have current immunizations as required by the Nebraska Department of Health and Human Services;
3. The center shall arrange with a physician and a psychiatrist for the medical and psychiatric care of the clients;
4. Each child/adolescent must have a medical examination annually as allowed in 471 NAC 33-000 ff.;

5. The center shall inform staff members of what medical care, including first aid, may be given by staff without specific physician orders. Staff must be instructed on how to obtain further medical care and how to handle emergency cases. The center shall ensure that -
   a. Staff members on duty must have satisfactorily completed current first aid and cardiopulmonary resuscitation training and have on file at the center a certificate of satisfactory completion as required by Department of Health and Human Services, Division of Public Health regulations;
   b. Each staff member must be able to recognize the common symptoms of illnesses in children/adolescents and to note any marked physical defects of children.
   c. A sterile clinical thermometer, a complete first aid kit, and clearly posted emergency phone numbers must be available, according to Department of Health and Human Services.

32-007.05E Hospital Admissions: The center shall make arrangements for the emergency admission of children from the center in case of serious illness, emergency, or psychiatric crisis. Parents, legal guardians, or the Department case manager or the case manager's supervisor must give permission and consent to treat for admission.

In the event that a client does require hospitalization while in a residential treatment center, NMAP will reimburse the treatment program for up to 15 days per hospitalization. This reimbursement is only available if the treatment placement is not used by another client.

32-007.05F Hospitalization or Death Reports: The center shall report any accident or illness requiring hospitalization to the parents or guardian immediately. The center shall immediately report any death to the parents or guardian, the Division of Medicaid and Long-Term Care, a law enforcement agency, and the county coroner. If the child is a Department ward, see 474 NAC 4-009.28D8.

32-007.05G Dental Care: Each child/adolescent must have an annual dental examination. If a child/adolescent has not had a dental exam in the twelve months before admission, an examination must occur within 90 days following admission. See 471 NAC 6-000 and 33-000 and 474 NAC 6-005.26F.

32-007.05H General Health: The center shall ensure the following:

1. Each child/adolescent must have enough sleep for the child/adolescent's age and physical and emotional condition at regular and reasonable hours, and under conditions conducive to rest. While clients are asleep, at least one staff member must be within hearing distance;
2. Children/adolescents must be encouraged and helped to keep themselves clean;
3. Bathing and toilet facilities must be properly maintained and kept clean;
4. Each child/adolescent must have a toothbrush, comb, an adequate supply of towels and washcloths, and personal toilet articles;
5. Menus must provide for a varied diet that meets a child/adolescent's daily nutritional requirements;
6. Each child/adolescent must have clothing for their exclusive use. The clothing must be comfortable and appropriate for the current weather conditions; and
7. The center must provide safe, age-appropriate equipment for indoor and outdoor play.

See 471 NAC 33-000.

32-007.05J Education: Educational services, when required by law, must be available. Education services must only be one aspect of the treatment plan, not the primary reason for admission or treatment. Educational services are not eligible for payment by the NMAP.

32-007.05K Religious Education: Children/adolescent must be provided with an opportunity to receive instruction in their religion. No child/adolescent may be required to attend religious services or to receive religious instructions if the child/adolescent chooses not to attend the services or receive instruction.

32-007.05L Discipline: Discipline must be diagnostic and remedial rather than punitive. Corporal punishment, verbal abuse, and derogatory remarks about the child/adolescent, the family, religion, or cultural background are prohibited. A child/adolescent may not be slapped, punched, spanked, shaken, pinched, or struck with an object by any staff of the center. Only staff members of the center may discipline children (see 474 NAC 6-005.26K) while in treatment.

32-007.05M Transition and Discharge Planning: Whenever a child or adolescent is transferred from one setting to another, discharge planning must be performed and documented, beginning at the time of admission (see 471 NAC 32-001.07A and 474 NAC 6-005.27H).

Facilities must meet the following standards regarding discharge planning:

1. Discharge planning must be based on the multidisciplinary treatment plan designed to achieve the client's discharge from residential treatment status to a less restrictive level of care at the most appropriate time;
2. Discharge planning must address the client's need for ongoing treatment, continuing education, and support for normal development following discharge;
3. Discharge planning must include identification of and transition into services needed following discharge;
4. The residential treatment facility shall arrange for prompt transfer of appropriate records and information to ensure continuity of care following the client's discharge;
5. A written discharge summary must be provided as part of the clinical record; and
6. The client's family and caseworker must be active participants in discharge planning. This participation must be clearly documented in the client's record.

32-007.05N Notification of Runaway Children: See 390 NAC 7-001.05.

32-007.05P Interstate Compact on the Placement of Children: The center shall comply with the interstate compact on the placement of children (see 474 NAC 6-005.27J).

32-007.05Q Medications: The center may possess a limited quantity of nonprescription medications and administer them under the supervision of designated staff. The center must follow all applicable regulations through the Department of Health and Human Services, Division of Public Health for storing and administering medications.

The center shall have written policies governing the use of psychotropic medications. Parents or the guardian of a client who receives psychotropic medication must be informed of the benefits, risks, side effects, and potential effects of medications. A parent or legal guardian's written informed consent for use of the medication must be obtained before giving the medication and filed in the client's record.

A child/adolescent's medication regime must be reviewed by the attending physician at least every seven days for the first 30 days and at least every 30 days thereafter.

32-007.06 Individual Treatment: To be covered by NMAP, individual treatment services must include -

1. Program philosophy: Residential treatment facilities must provide intensive family-centered, community-based, developmentally appropriate services under the direction of a supervising practitioner.
   a. These services must be able to meet the special needs of families, including the "identified client" in the treatment facility. Families must be involved in treatment and discharge planning. For wards of the Department, the case manager must also be involved in treatment and discharge planning.
   b. The program intensity must be such that direct care staff, the client in treatment, and/or the client's family have access to professional staff on an "as needed" basis, determined by the client's condition.
2. Active treatment, which must be -
   a. Treatment provided under a multi-disciplinary treatment plan reviewed and approved by the supervising practitioner. This plan will be developed within 14 days of admission by a multi-disciplinary team of professional staff members. The treatment plan must be for a primary psychiatric diagnosis and must be based on a thorough evaluation of the client's restorative needs and the client's potential. The treatment plan must be reviewed at least every 30 days by the multi-disciplinary team.

      The goals and objectives documented on the treatment plan must reflect the recommendations included in the Pre-treatment Assessment and the integration of input from the supervising practitioner and the therapist. The treatment interventions provided must reflect these recommendations, goals, and objectives. Evaluation of the treatment plan by the therapist and the supervising practitioner should reflect the client's response to the treatment interventions based on the recommendations, goals and objectives.
   b. In compliance with 471 NAC 32-001.07, Treatment Planning; and
   c. In compliance with 471 NAC 32-001.06, Active Treatment.
3. Medically necessary services, which must be an appropriate level of care based on documented pre-treatment assessment (see 471 NAC 32-001.01) including a comprehensive diagnostic workup and supervising practitioner-ordered treatment.

32-007.07 Documentation in the Client's Clinical Record: The center must maintain accurate clinical records indicating the degree and intensity of the treatment provided to clients who receive services in the residential treatment facility. For residential services, clinical records must stress the treatment intervention components of the clinical record, including history of findings and treatment provided for the psychiatric condition for which the client is in the facility. The clinical record must include the requirements stated in 471 NAC 32-001.05 and -

1. The identification data, including the client's legal status (i.e., voluntary admission, Board of Mental Health commitment, court mandated);
2. A provisional or admitting diagnosis which is determined for every client at the time of admission and includes the diagnoses of intercurrent diseases as well as the psychiatric diagnoses;

3. The statements of others regarding the client's problems and needs, as well as the client's statement of their problems and needs;
4. The pre-treatment assessment, including a medical/psychiatric history, which contains a record of mental status and notes the onset of illness/problems, the circumstances leading to admission, attitudes, behavior, estimate of intellectual functioning, memory functioning, orientation, and an inventory of the client's strengths in a descriptive, not interpretative, fashion;
5. A complete psychological evaluation;
6. A complete neurological examination, when indicated;
7. A social history sufficient to provide data on the client's relevant past history, present situation, social support system, community resource contacts, and other information relevant to good treatment and discharge planning;
8. A thorough family assessment;
9. Reports of consultations, psychological evaluations, electroencephalograms, dental records, and special studies;
10. The treatment received by the client, which is documented in a manner and with a frequency to ensure that all active therapeutic efforts, such as individual, group, and family psychotherapy, drug therapy, milieu therapy, occupational therapy, recreational therapy, nursing care, and other therapeutic interventions, are included;
11. Progress notes must be recorded by all professional staff and, when appropriate, others significantly involved in active treatment modalities, following each contact. The frequency is determined by the individual treatment plan and the condition of the client, but should be recorded at least daily. Progress notes must contain a concise assessment of the client's progress and recommendations for revising the treatment plan as indicated by the client's condition. Child care workers must maintain 24-hour documentation of a client's whereabouts and activities;
12. The transition plan and discharge summary, including a summary of the client's and family's treatment, recommendations for appropriate services concerning follow-up, and a brief summary of the client's condition on discharge;
13. The psychiatric diagnosis contained in the final diagnosis written in the terminology of the American Psychiatric Association's Diagnostic and Statistical Manual; and
14. The client's response to therapeutic leave days prescribed by the supervising practitioner under the treatment plan. The client's, family's, or guardian's response to time spent outside the facility must be entered in the client's clinical record.

All documents from the client's medical record submitted to the Division of Medicaid and Long-Term Care must contain sufficient information for identification (i.e., client's name, date of service, provider's name).

32-007.08 Utilization Review: All facilities must have a utilization review protocol for their services.

32-007.09 Inspection of Care (IOC): The Division of Medicaid and Long-Term Care or its designee's inspection of care team will conduct inspection of care reviews for psychiatric residential treatment facilities. See 471 NAC 32-001.09 and 471 NAC 32-001.10.

32-007.10 Documentation for Claims: The following documentation is required and kept in the client's clinical record for all claims for residential treatment services. The facility will be notified in writing if that occurs:

1. The treatment plan;
2. Orders by the supervising practitioner; and
3. Progress notes for all disciplines.

All claims are subject to utilization review by the Department prior to payment.

32-007.10A Exception: Additional documentation from the client's clinical record may be requested by the Department prior to considering authorization of payment.

32-007.11 Costs Not Included in the Residential Treatment Per Diem: The mandatory and optional services are considered to be part of the per diem for residential treatment services. The following charges can be reimbursed separately from the residential treatment per diem when the services are necessary, part of the client's overall treatment plan, and in compliance with NMAP policy:

1. Direct client services performed by the supervising practitioner;
2. Prescription medications (including injectable medications);
3. Direct client services performed by a physician other than the supervising practitioner; and
4. Treatment services for a physical injury or illness provided by other professionals.

If the client is enrolled with another managed care vendor for medical-surgical services, it may be necessary to pursue prior authorization or referral with that entity.

32-007.12 Procedure Code and Description for Residential Treatment Services: HCPCS/CPT procedure codes used by NMAP are listed in the Nebraska Medicaid Practitioner Fee Schedule at 471-000-532.

32-008 Inpatient Mental Health and Substance Abuse Services: Inpatient mental health and substance abuse services in a psychiatric hospital or unit or substance abuse treatment unit are available to clients age 20 or younger when the client participates in a HEALTH CHECK (EPSDT) screen and the treatment is medically necessary. Inpatient services in a psychiatric hospital or unit or substance abuse treatment unit must be family centered, community based, culturally competent, and developmentally appropriate.

Inpatient services are medically necessary services provided to an inpatient as defined in 471 NAC 10-001.02. The care and treatment of an inpatient with a primary psychiatric or substance abuse diagnosis must be under the direction of a psychiatrist or physician who meets the state's licensing criteria and is enrolled as a provider with NMAP with a primary specialty of psychiatry or substance abuse. Inpatient hospital services must be prior-authorized by the Division of Medicaid and Long-Term Care or its designee. In addition, out-of-state hospitalizations must be approved by the Department.

Providers must encourage family members to be involved in the assessment of the client, the development of the treatment plan, and all aspects of the client's treatment unless prohibited by the client, through legal action, or because of federal confidentiality laws.

Providers must be available to schedule meetings and sessions in a flexible manner to accommodate and work with a family's schedule. This includes the ability to schedule sessions at a variety of times including weekends or evenings.

The provider must document their attempts to involve the family in treatment plan development and treatment plan reviews. A variety of communication means should be considered. These may include, but should not be limited to, including the family via conference telephone calls, using registered letters to notify the family of meetings, and scheduling meetings in the evening and on weekends.

Services for wards of the Department must be prior-authorized by and consent for treatment must be obtained from the ward's case manager or the case manager's supervisor.

32-008.01 Provider Agreement: A hospital which provides inpatient services shall complete Form MC-20, "Medical Assistance Hospital Provider Agreement," (see 471-000-91) and submit the completed form to the Department for approval and enrollment as a provider. The hospital shall submit with the provider agreement -

1. A complete description of the psychiatric and/or substance abuse program and the elements of the program (i.e., policies and procedures, staffing, services, etc.);
2. Documentation that the inpatient program meets the family-centered, community-based requirements in 471 NAC 32-001;
3. A description of how family therapy services will be provided;
4. A description of how the hospital services will interface with community services for discharge planning and service provision after discharge;
5. A copy of the most recent JCAHO or AOA accreditation survey; and
6. Any other information requested.

Any facility requesting a provider agreement shall make the facility available for an on-site review before issuance of a provider agreement.

32-008.02 Standards for Participation for Inpatient Mental Health and Substance Abuse Service Providers: A hospital that provides inpatient services must meet the following standards for participation to ensure that payment is made only for active treatment. The hospital -

1. Is maintained for the care and treatment of patients with primary psychiatric or substance abuse disorders;
2. Is licensed or formally approved as a hospital by the Nebraska Department of Health and Human Services, Division of Public Health, or if the hospital is located in another state, the officially designated authority for standard - setting in that state;
3. Is accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) or the American Osteopathic Association (AOA);
4. Meets the requirements for participation in Medicare for psychiatric hospitals;
5. Has in effect a utilization review plan applicable to all Medicaid clients;
6. Must have medical records that are sufficient to permit the Division of Medicaid and Long-Term Care to determine the degree and intensity of treatment furnished to the client (see 471 NAC 32-008.06); and
7. Must meet staffing requirements the Division of Medicaid and Long-Term Care finds necessary to carry out an active treatment program (see 471 NAC 32-008.03).

A distinct part of a hospital may be considered a psychiatric or substance abuse unit if it meets the standards for participation, even though the hospital of which it is a part does not.

32-008.03 Staffing Standards for Participation: The hospital must have staff adequate in number and qualified to carry out an active program of treatment for individuals who are provided services in the hospital. The hospital shall meet the following standards.

1. Hospital Personnel: Hospitals which provide inpatient psychiatric or substance abuse services must be staffed with the number of qualified professional, technical, and supporting personnel, and consultants required to carry out an intensive and comprehensive active treatment program that includes evaluation of individual and family needs; establishment of individual and family treatment goals; and implementation, directly or by arrangement, of a broad-range therapeutic program including, at least, professional medical, surgical, nursing, social work, psychological, and activity therapies required to carry out an individual treatment plan for each patient and their family. The following standards must be met:
   a. Qualified professional and technical personnel must be available to evaluate each patient at the time of admission, including diagnosis of any intercurrent disease. Services necessary for the evaluation include -
      (1) Laboratory, radiological, and other diagnostic tests;
      (2) Obtaining psychosocial data;
      (3) A complete family assessment (see 32-001);
      (4) Carrying out psychiatric and psychological evaluations; and
      (5) Completing a physical examination, including a complete neurological examination when indicated, shortly after admission;

b. The number of qualified professional personnel, including consultants and technical and supporting personnel, must be adequate to ensure representation of the disciplines necessary to establish short-range and long-term goals; and to plan, carry out, and periodically revise a treatment plan for each client based on scientific interpretation of -
   (1) The degree of physical disability and indicated remedial or restorative measures, including nutrition, nursing, physical medicine, and pharmacological therapeutic interventions;
   (2) The degree of psychological impairment and appropriate measures to be taken to relieve treatable distress and to compensate for nonreversible impairments where found;
   (3) The capacity for social interaction, and appropriate nursing measures and milieu therapy to be undertaken, including group living experiences, occupational and recreational therapy, and other prescribed activities to maintain or increase the individual's capacity to manage activities of daily living; and
   (4) The environmental and physical limitations required to protect the client's health and safety with a plan to compensate for these deficiencies and to develop the client's potential for return to his/her own home, a foster home, a skilled nursing facility, a community mental health center, or other alternatives to full-time hospitalization.

2. Director of Inpatient Services and Medical Staff: Inpatient mental health services must be under the supervision of a clinical director, service chief, or the equivalent who is qualified to provide the leadership required for an intensive treatment program. The number and qualifications of physicians must be adequate to provide essential mental health services. The following standards must be met:
   a. The clinical director, service chief, or equivalent must meet the training and experience requirements for a psychiatrist;
   b. The medical staff must be qualified legally, professionally, and ethically for the positions to which they are appointed;
   c. The number of physicians must be commensurate with the size and scope of the treatment program; and
   d. The physician's personal involvement in all aspects of the client's care must be documented in the client's medical record (i.e., physician's orders, progress notes, nurses notes).

   The psychiatrist must be available, in person or by telephone, to provide assistance and direction as needed.

3. Availability of Physicians and Other Personnel: Physicians and other appropriate professional personnel must be available at all times to provide necessary medical, surgical, diagnostic, and treatment services, including specialized services. If medical, surgical, diagnostic, and treatment services are not available within the hospital, qualified consultants or attending physicians must be immediately available, or a satisfactory arrangement must be established for transferring patients to a general hospital enrolled as Medicaid providers.

4. Nursing Services: Nursing services must be under the direct supervision of a registered professional nurse who is qualified by education and experience for the position. The number of registered professional nurses, licensed practical nurses, and other nursing personnel must be adequate to formulate and carry out the nursing components of a treatment plan for each client. The following standards must be met:
   a. The registered professional nurse supervising the nursing program must have a master's degree in psychiatric or mental health nursing or its equivalent from a school of nursing accredited by the National League for Nursing, or must be qualified by education or experience in the care of the mentally ill or substance abusers, and have demonstrated competence to -
      (1) Participate in interdisciplinary formulation of treatment plans;
      (2) Give skilled nursing care and therapy; and
      (3) Direct, supervise, and train others who assist in implementing and carrying out the nursing components of each client's treatment plan;
   b. The staffing pattern must ensure the availability of a registered professional nurse 24 hours each day for -
      (1) Direct care;
      (2) Supervising care performed by other nursing personnel; and
      (3) Assigning nursing care activities not requiring the services of a professional nurse to other nursing service personnel according to the client's needs and the preparation and competence of the nursing staff available;
   c. The number of registered professional nurses, including nurse consultants, must be adequate to formulate a nursing care plan in writing for each client and to ensure that the plan is carried out; and
   d. Registered professional nurses and other nursing personnel must be prepared by continuing in-service and staff development programs for active participation in interdisciplinary meetings affecting the planning or implementation of nursing care plans for patients. The meetings include diagnostic conferences, treatment planning sessions, and meetings held to consider alternative facilities and community resources.
5. Psychological Services: The psychological services must be under the supervision of a licensed psychologist. The psychology staff, including consultants, must be adequate in numbers and be qualified to plan and carry out assigned responsibilities. The following standards must be met:
   a. The psychology department or service must be under the supervision of a licensed psychologist;
   b. Psychologists, consultants, and supporting personnel must be adequate in number and be qualified to assist in essential diagnostic formulations, and to participate in -
      (1) Program development and evaluation of program effectiveness;

(2) Training and program evaluation activities;
(3) Therapeutic interventions, such as milieu, individual, or group therapy; and
(4) Interdisciplinary conferences and meetings held to establish diagnoses, goals, and treatment programs; and

c. Psychotherapy must be ordered and directed by a psychiatrist/physician.

6. Social Work Services and Staff: Social work services must be under the supervision of a qualified social worker. The social work staff must be adequate in numbers and be qualified to fulfill responsibilities related to the specific needs of individual clients and their families, the development of community resources, and consultation with other staff and community agencies. The following standards must be met:
   a. The director of the social work department or service must have a master's degree from an accredited school of social work and must meet the experience requirements for certification by the Academy of Certified Social Workers; and
   b. Social work staff, including other social workers, consultants, and other assistants or case aides, must be qualified and numerically adequate to -
      (1) Conduct preadmission evaluations; and
      (2) Provide psychosocial data for diagnosis and treatment planning, and for direct therapeutic services to patients, patient groups, or families; to develop community resources, including family or foster care programs; to conduct appropriate social work program evaluation and training activities; and to participate in interdisciplinary conferences and meetings concerning diagnostic formulation and treatment planning, including identification and utilization of other facilities and alternative forms of care and treatment.
7. Qualified Therapists, Licensed Alcohol and Drug Counselors, Consultants, Volunteers, Assistants, Aides: Qualified therapists, consultants, volunteers, assistants, or aides must be sufficient in number to provide comprehensive therapeutic activities, including occupational, recreational, and physical therapy, as needed, to ensure that appropriate treatment is provided to each client, and to establish and maintain a therapeutic milieu. The following standards must be met:
   a. Substance Abuse Counseling Services must be provided by licensed alcohol and drug counselors.

b. Occupational therapy services must be provided under the supervision of a graduate of an occupational therapy program approved by the Council on Education of the American Medical Association who is licensed by the Nebraska Department of Health and Human Services, Division of Public Health. In the absence of a full-time, fully-qualified occupational therapist, an occupational therapy assistant may function as the director of the activities program with consultation from a fully-qualified occupational therapist.

c. When physical therapy services are offered, the services must be given by or under the supervision of a qualified physical therapist who is a graduate of a physical therapy program approved by the Council on Medical Education of the American Medical Association in collaboration with the American Physical Therapy Association or its equivalent and is licensed by the Nebraska Department of Health and Human Services, Division of Public Health. In the absence of a full-time, fully-qualified physical therapist, physical therapy services must be available by arrangement with a certified local hospital, or by consultation or part-time services furnished by a fully-qualified physical therapist;

d. Educational Program Services: Services, when required by law, must be available. Educational Services must only be one aspect of the treatment plan, not the primary reason for admission or treatment. Educational services are not covered for payment by the Nebraska Medical Assistance Program (Medicaid).

e. Recreational or activity therapy services must be available under the direct supervision of a member of the staff who has demonstrated competence in therapeutic recreation programs;

f. Other occupational therapy, recreational therapy, activity therapy, and physical therapy assistants or aides must be directly responsible to qualified supervisors and must be provided special on-the-job training to fulfill assigned functions;

g. The total number of rehabilitation personnel, including consultants, must be sufficient to -
   (1) Permit adequate representation and participation in interdisciplinary conferences and meetings affecting the planning and implementation of activity and rehabilitation programs, including diagnostic conferences; and
   (2) Maintain all daily scheduled and prescribed activities, including maintenance of appropriate progress records for individual clients; and

h. Volunteer service workers must be -
   (1) Under the direction of a paid professional supervisor of volunteers;
   (2) Provided appropriate orientation and training; and
   (3) Available daily in sufficient numbers to assist clients and their families in support of therapeutic activities.

32-008.04 Coverage Criteria for Inpatient Hospital Services: The Nebraska Medical Assistance Program covers inpatient mental health services for clients age 20 and younger when the services meet the criteria in 471 NAC 32-001 and:

1. The client must be treated by a psychiatrist or physician at least six out of seven days, or more often, if medically necessary, and the interaction must be documented in the client's medical record.
2. A licensed physician serves as the attending physician for psychiatric care and defines the medical necessity and active treatment requirements noted in 471 NAC 32-001, "General Requirements."
3. Therapeutic passes for clients with primary psychiatric or substance abuse diagnoses from hospitals which provide inpatient services. Therapeutic passes are an essential part of the treatment of some clients. Documentation of the client's continued need for acute care must follow the overnight therapeutic passes. Payment for hospitalization beyond a second pass will be denied based on medical necessity. The hospital is not paid for therapeutic passes or leave days.
4. Unplanned leaves of absence from inpatient hospital care: The hospital is not paid for unplanned leave of absence days from an inpatient hospital. If a client returns to the hospital after an unplanned leave of absence, the hospital must contact the appropriate agency to obtain prior authorization for the admission.

32-008.04A Professional and Technical Components for Hospital Diagnostic and Therapeutic Services: For regulations regarding professional and technical components for diagnostic and therapeutic hospital services, the elimination of combined billing, and non-physician services and items provided to hospital patients, see 471 NAC 10-000.

32-008.04B Educational Services: Educational services, when required by law, must be available, though not necessarily provided by the hospital. Educational services must be only one aspect of the treatment plan, not the primary reason for admission or treatment. Educational services are a non-reimbursable item under NMAP.

32-008.05 Admission Criteria for Inpatient Mental Health and Substance Abuse Services: For inpatient mental health and substance abuse services to be covered by NMAP, the client must participate in a HEALTH CHECK (EPSDT) screen, the client must be in imminent danger of causing harm to self or others, and one or more of the following problems must be present:

1. The client needs a specific form of acute mental health or substance abuse treatment that can only be provided in the hospital and the structured, restrictive environment of the hospital is necessary for the client's treatment;
2. Specific observations are needed for evaluation and disposition;
3. Specific observations are needed for following treatment, or control of behavior is necessary for effective somatic therapy or psychotherapy;
4. The client's current condition is a serious threat to his/her adaptation to life and continuing developmental process, and hospitalization at this time is necessary to control this factor;
5. The client is experiencing mental health and/or substance abuse symptoms, the magnitude of which is not tolerable to self or society and that cannot be alleviated through treatment at a less intensive level of care;
6. The client has a clear history of excessive use of alcohol and/or other mood altering substances that cannot be treated at a less intensive level of care;
7. The client is unable to be cared for by self or others, due to a diagnosable major mental health or substance abuse disorder;
8. The client requires and receives "active treatment" as defined in the Code of Federal Regulations, which is available only in an inpatient setting; or
9. Ambulatory care services in the community do not meet the treatment needs of the client. Note: In those communities where outpatient resources are not available, the community pattern of referral must be used when appropriate.

32-008.05A Guidelines for Interpretation: Admission of a child or adolescent to an acute care facility or an acute level of care may be made only after all resources at a less restrictive level have been explored and deemed inappropriate.

The following will not be accepted as adequate medical indicators for hospital inpatient admission:

1. Non-availability of foster home, group home, halfway house, residential treatment or other placement alternatives;
2. Admission to support or arrange placement in foster home, group home, halfway house, or residential treatment;
3. Admission solely for emergency placement or protective custody;
4. Admission due to failure of current placement;
5. Admission due to lack of parenting skills;
6. Reason for acute level of care is to obtain Medicaid benefits that would otherwise not be reimbursed;

7. Admission to avoid placement in the criminal justice system;
8. Admission for conduct disorders or behavioral issues that do not demonstrate an imminent danger to self or others;
9. Truancy;
10. Admission to support the need for alternative educational needs or for school phobia;
11. Social and family problems, including placement for runaways; and
12. Psychometric evaluation including mental retardation and learning disabilities.

32-008.05A1 Patient Assessment: Admission to an acute care facility must meet elements #1 and #2 (listed below) plus at least one other element from this patient assessment section. The additional element must be as a result of the major diagnosable mental health or substance abuse disorder referred to in element #1. In addition, one element from the acute services section (471 NAC 32-001.03A2) must be met.

Elements #1 and #2 must be met on all admissions.

1. Documented evidence of a major diagnosable mental health or substance abuse disorder that necessitates 24-hour medical supervision and daily physician contact.
2. Documented initial treatment plan with provisions for -
    a. Resolution of acute medical problems;
    b. Evaluation of, and needs assessment for, medications;
    c. Protocol to ensure patient's safety;
    d. Discharge plan initiated at the time of admission.

Plus one of the following:

3. Demonstrates imminent danger to self or others at the time of admission evidenced by at least one of the following:
    a. Suicide attempt or specific suicide plan with access to means;
    b. Danger to others through a specific action or activity;
    c. Command hallucination with suicidal or homicidal content;
    d. Hallucinations, delusional behavior, or other bizarre psychotic behavior;
    e. The use of IV drugs or inhalants.
4. Presence of other behavior/symptoms to such a degree or in such a combination that acute care is the least restrictive treatment available as demonstrated by at least one of the following:
    a. Physical aggression toward family, peers, or teachers which could not be considered self protective;
    b. Explosive behavior without provocation or serious loss of impulse control;

c. Dangerous, assaultive, uncontrolled or extreme impulsive behavior which puts the patient at significant risk, e.g., running into traffic, playing/setting fires, self-abuse, and which cannot be prevented in a non-acute setting;
d. Severe impairment in concentration and/or hyperactivity;
e. Excessive use of alcohol or other mood altering substances;
f. Behaviors consistent with an acute mental health or substance abuse disorder which may include significant mental status changes; and there is documented evidence that no medical condition would account for the symptoms;

5. Severe impairment in psychosocial functioning as demonstrated by at least one of the following:
   a. Psychotic behavior, delusions, paranoia, or hallucinations;
   b. Severe decompensation and interference with baseline functioning;
6. Documented failure of current intensive outpatient treatment including two or more of the following indications:
   a. Intensification or perseverance of severe psychiatric symptoms;
   b. Noncompliance with medication regime;
   c. Lack of therapeutic response to medication;
   d. Lack of patient participation in or response to outpatient treatment modalities;
7. Frequent intoxication and the inability or unwillingness to abstain from substance use after experiencing significant consequences from substance use;
8. Admissions ordered by the court will be covered when accompanied by substantiation of medical necessity.

Documentation supports the need for controlled, clinical observation and psychiatric evaluation, where acute care is the least restrictive treatment alternative.

32-008.05A2 Acute Services:

Justification for Continued Stay: The patient must meet elements #1 and #2 plus two elements from 2 through 7 for the approval of continued stay.

Elements #1 and #2 must be met at all continued stay reviews.

1. Evidence of a major mental health or substance abuse disorder that necessitates 24-hour medical supervision and family physician contact.
2. A comprehensive treatment plan/clinical pathway of inpatient care must be completed within 72 hours of admission and implemented to facilitate the patient's progression toward living in a less supervised setting. Documentation must support the patient's and/or family's active involvement with the treatment goals and with revisions in the treatment plan as appropriate based on the patient's progress or lack of progress.

Plus two of the following:

3. Isolation, seclusion, or restraint procedures within the last 72 hours requiring 24-hour medical supervision and supported by medical record documentation.
4. Continuing evidence of symptoms and/or behaviors reflecting significant risk, imminent danger, or actual demonstrated danger to self or others; requiring suicide/homicide precautions (1:1 staffing), close observation, step down precautions (every 15-60 minute checks).
5. Monitoring/adjustment of psychotropic medication(s) related to lack of therapeutic effect/complication(s) in the presence of complicating medical and psychiatric conditions necessitating 24-hour medical supervision and supported by medical record documentation.
6. Persistence of psychotic symptoms and continued temporary (not chronic) inability of the patient to perform the activities of daily living or meet their basis needs for nutrition and safety due to a mental health or substance abuse disorder or the temporary mental state of the patient.
7. Continued need for 24-hour medical supervision, reevaluation and/or diagnosis of a patient exhibiting behaviors consistent with acute psychiatric or substance abuse disorder. Referral for physician review is necessary if symptoms are unimproved or worse within any seven-day interval.

32-008.05B Prior Authorization for Services: Admissions must be prior authorized by the Department or its designee.

32-008.05C Signs and Symptoms: In addition to the admission criteria, one or more of the following signs or symptoms of the problem must be present:

1. A suicide attempt that requires acute medical intervention or suicidal ideation with a lethal plan and the means to carry out this plan;
2. Psychiatric decompensation to a level in which the client is not able to communicate or perform life-sustaining activities of daily living;
3. Delusions or hallucinations that significantly impair the client's ability to communicate or perform life-sustaining activities of daily living;
4. Catatonia;
5. The presence of combined illnesses where neurological or other disease process coexists with a psychiatric disturbance, demanding special diagnostic or treatment interventions, which exceed non-hospital capacity;
6. Aggression to others causing physical injury or homicidal ideation with a lethal plan and the means to carry out the plan, that is the result of a severe emotional psychiatric decompensation;
7. Medication initiation or change when the client has a documented history of reactions to psychotropic medications that have resulted in the need for acute medical care in a hospital or an emergency room; and
8. Excessive use of mood altering substances leading to frequent intoxication, periods of blackouts, or loss of consciousness.

32-008.06 Documentation in the Client's Medical Record: The medical records maintained by a hospital permit determination of the degree and intensity of the treatment provided to clients who receive services in the hospital. For inpatient services, medical records must stress the psychiatric and substance abuse components of the record, including history of findings and treatment provided for the psychiatric condition for which the client is hospitalized. In addition to the information required in 471 NAC 32-001, the medical record must include -

1. The identification data, including the client's legal status (i.e., voluntary admission, Board of Mental Health commitment, court mandated);
2. A provisional or admitting diagnosis which is made on every patient at the time of admission and includes the diagnoses of intercurrent diseases as well as the psychiatric or substance abuse diagnoses;
3. The complaint of others regarding the client, as well as the client's comments;
4. The psychiatric evaluation, including a medical history, which contains a record of mental status and notes the onset of illness, the circumstances leading to admission, attitudes, behavior, estimate of intellectual functioning, memory functioning, orientation, and an inventory of the client's strengths in a descriptive, not interpretative, fashion;
5. A complete neurological examination, when indicated, recorded at the time of the admitting physical examination;
6. A social history sufficient to provide data on the client's relevant past history, present situation, social support system, community resource contacts, and other information relevant to good treatment and discharge planning;
7. A complete family assessment as described in 471 NAC 32-001;
8. Reports of consultations, psychological evaluations, electroencephalograms, dental records, and special studies;
9. The client's pre-treatment assessment (see 471 NAC 32-001.01) (when applicable);
10. The client's treatment plan;
11. The treatment received by the client, which is documented in a manner and with a frequency to ensure that all active therapeutic efforts, such as individual, group, and family psychotherapy, drug therapy, milieu therapy, occupational therapy, recreational therapy, nursing care, and other therapeutic interventions, are included;
12. Progress notes which are recorded by the psychiatrist/physician, nurse, social worker, and, when appropriate, others significantly involved in active treatment modalities. The frequency is determined by the condition of the client, but progress notes must be recorded daily by nursing staff, at each contact by psychiatrist or physician and by all other therapeutic staff (such as O.T., R.T.). Progress notes must contain a concise assessment of the client's progress and recommendations for revising the treatment plan as indicated by the client's condition;

13. The psychiatric or substance abuse diagnosis contained in the final diagnosis written in the terminology of the American Psychiatric Association's Diagnostic and Statistical Manual;
14. Therapeutic leave days prescribed by the physician under the treatment plan. The client's response to time spent outside the hospital must be entered in the client's hospital medical record;
15. Transition and discharge planning documentation;
16. Proof of family and community involvement;
17. A copy of the MC-14 certification; and
18. The discharge summary, including a recapitulation of the client's hospitalization, recommendations for appropriate services concerning follow-up, and a brief summary of the client's condition on discharge.

All documents from the client's medical record submitted must contain sufficient information for identification (i.e., client's name, date of service, provider's name).

32-008.07 Certification and Recertification by Psychiatrists/Physicians for Inpatient Hospital Services

32-008.07A Certification and Recertification by Psychiatrists/Physicians: The NMAP pays for covered inpatient hospital services only if a physician certifies and recertifies at designated intervals, the medical necessity for the services of the hospital inpatient stay. Appropriate supporting material may be required. The certification or recertification statement must document the medical necessity for the admission to and continued hospitalization for inpatient mental health or substance abuse treatment, based on a current evaluation of the client's condition.

For clients admitted to a hospital, a physician's certification by written order for admission is required at the time of admission for inpatient services. All admissions for clients must be prior-authorized by the Department-contracted review organization.

For wards of the Department, the facility must provide documentation to the ward's case manager upon request. Failure to do so could result in nonpayment of services.

32-008.07B Failure to Certify or Recertify: If a hospital fails to obtain the required certification and recertification statements in an individual case, the NMAP shall not make payment for the case.

32-008.08 Hospital Utilization Review (UR): See 471 NAC 10-000 ff. A site visit by Medicaid staff or their designee for purposes of utilization review may be required for further clarification.

32-008.09 Payment for Inpatient Hospital Mental Health or Substance Abuse Services: See 471 NAC 10-010.03 ff.

32-008.09A Billing: Providers shall submit claims for inpatient hospital services on Form CMS-1450 or the standard electronic Health Care Claim: Institutional transaction (ASC X12N 837).

32-008.10 Other Regulations: In addition to the regulations regarding mental health and substance abuse services, all regulations in the Nebraska Department of Health and Human Services Manual apply, unless stated differently in this section. For inpatient services provided by an IMD, public or private, see 471 NAC 32-009 ff.

32-008.11 Limitations: For inpatient mental health and substance abuse services, the following limitations apply:

1. Care must be supervised by a physician for mental health and a physician for substance abuse. All inpatient hospital services must be prior-authorized by the Department contracted peer review organization or management designee.
2. Payment for inpatient hospital services is made according to 471 NAC 10-010.03 ff.

32-008.12 Form Completion: Inpatient mental health and substance abuse service providers shall -

1. Complete Form MC-20 and be approved and enrolled with the Department as a provider of inpatient hospital services (class or care 06); and
2. Submit all claims for inpatient hospital services an appropriately completed Form CMS-1450 or the standard electronic Health Care Claim: Institutional transaction (ASC X12N 837).

Payment for approved services is made to the hospital.

32-008.13 Exceptions: Additional documentation from the client's medical record may be requested by the NMAP consultants prior to considering authorization of payment.

32-009 Inpatient Mental Health Services for Clients 20 and Younger in Institutions for Mental Disease (IMD's): Inpatient mental health services in an Institution for Mental Disease (IMD's) are available to clients age 20 and younger when the client participates in a HEALTH CHECK (EPSDT) screen, and the treatment is medically necessary. Inpatient mental health services in an IMD must be family centered and community based culturally competent, and developmentally appropriate.

Services for wards of the Department must be prior-authorized by and consent for treatment must be obtained from the ward's case manager or the case manager's supervisor.

32-009.01 Legal Basis: The Nebraska Medical Assistance Program (NMAP) covers IMD services under 42 CFR 431.620(b), 435.1009; 440.140; 440.160; Part 441, Subparts C and D; Part 447, Subparts B and C; Part 456, Subparts D and I; and Part 482. The Department provides IMD services under the Family Policy Act, Sections 43-532 through 534. Reissue Revised Statute of Nebraska, 1943.

32-009.02 Definition of an IMD: 42 CFR 435.1009 defines an IMD as "an institution that is primarily engaged in providing diagnosis, treatment or care of persons with mental diseases, including medical attention, nursing care and related services. Whether an institution is an institution for mental diseases is determined by its overall character as that of a facility established and maintained primarily for the care and treatment of individuals with mental diseases, whether or not it is licensed as such. An institution for the mentally retarded is not an institution for mental diseases." This is limited to free-standing facilities which are not excluded units of acute care hospitals.

32-009.03 Covered Services: Under 42 CFR 440.160, NMAP covers services in IMD's for individuals age 20 and younger.

32-009.04 Standards for Participation: To participate in the NMAP, the IMD must -

1. Be in conformity with all applicable federal, state, and local laws;
2. Be licensed as a hospital by the Nebraska Department of Health and Human Services, Division of Public Health or the licensing agency in the state where the IMD is located;
3. Be certified as meeting the conditions of participation for hospitals in 42 CFR Part 482;
4. Be accredited by the Joint Commission of Accreditation of Healthcare Organizations (JCAHO) or the American Osteopathic Association (AOA), and submit a copy of the most recent accreditation survey with Form MC-20;
5. Meet the definition of an IMD as stated in 471 NAC 32-009.02 (above);
6. Meet the program and operational definitions and criteria contained in the Nebraska Department of Health and Human Services Manual;
7. Meet the current JCAHO or AOA standards of care; and
8. Meet all requirements in 471 NAC 32-001 and 471 NAC 32-008.

32-009.04A Provider Agreement: The provider shall complete Form MC-20 and submit the form, along with a copy of its current JCAHO or AOA accreditation survey, program, policies, and procedures to the Department to enroll in NMAP as a provider. If approved, the Department notifies the IMD of its provider number.

32-009.04B Annual Update: With the annual cost report, the provider shall submit a copy of all program information, their most recent license and accreditation certificates, and any other information specifically requested by the Department. Claims will not be paid if this has not been received and approved.

32-009.04C Monthly Reports: The IMD shall submit a monthly report to the Division of Medicaid and Long-Term Care. The report must contain -

1. The names of all Medicaid clients admitted or discharged during the month; and
2. The date of each Medicaid client's admission or discharge.

The report must be submitted by the 15th of the following month.

32-009.04D Record Requirements: Transfer to another IMD or readmission constitutes a new admission for the receiving facility.

The psychiatrist shall complete, sign, and date Form MC-14 within 48 hours after admission. If an individual applies for assistance while in the facility, copies of the admission notes and plan of care must be attached to the signed Form MC-14 to certify that inpatient services are or were needed.

32-009.04D1 An Individual Who Applies For NMAP While in the IMD: For an individual who applies for NMAP while in the IMD, the certification must be -

1. Made by the team that develops the individual plan of care (see 471 NAC 32-009.09F);
2. Cover any period before application for which claims are made.

When Medicaid eligibility is determined, authorization for previous and continued care must be obtained from the Department contracted peer review organization or management designee.

32-009.05 General Definitions: The following definitions are used in this section:

Interdisciplinary Team: The team responsible for developing each client's individual plan of care. The team must include a board-certified psychiatrist. The team must also include at least two of the following:

1. Licensed Mental Health Practitioner;
2. A registered nurse with specialized training or one year's experience in treating individuals with mental illness;
3. An occupational therapist who is licensed, if required by state law, and who has specialized training or one year's experience in treating mentally ill individuals; or
4. A clinical psychologist.

Inpatient Hospital Services for Individuals Age 20 or Younger in Institutions for Mental Disease (IMD's): Services provided under the direction of a psychiatrist for the care and treatment of clients age 20 and younger in an institution for mental disease that meets the requirements of 42 CFR 440.160.

Inspection of Care Team: The Department or designee's inspection of care team, consisting of a psychiatrist knowledgeable about mental institutions, a qualified registered nurse, and other appropriate personnel as necessary who conduct inspection of care reviews under 42 CFR 456.600-614 and 471 NAC 32-009.07 ff.

Medical Review Organization: A review body contracted by the Department, responsible for pre-admission certification and concurrent and retrospective reviews of care.

32-009.06 Payment for IMD Services: See 471 NAC 10-010.03 ff.

32-009.06A Therapeutic Passes from Institution for Mental Disease Settings: For some psychiatric clients, therapeutic passes are an essential part of treatment. For those clients, documentation of the client's continued need for psychiatric care must follow the overnight therapeutic passes. Payment for hospitalization beyond a second pass is not available.

32-009.06B Unplanned Leaves of Absence from Institution for Mental Disease Settings: Payment for hospitalization during an unplanned leave of absence from inpatient settings is not available. If a client returns to a hospital after an unplanned absence, the readmission must be approved by the Department contracted peer review organization or management designee.

32-009.07 Inspections of Care: Under 42 CFR 456, Subpart I, the Department or designee's inspection of care team shall periodically inspect the care and services provided to clients in each IMD under the following policies and procedures.

32-009.07A Inspection of Care Team: The inspection of care team must meet the following requirements:

1. The inspection of care team must have a psychiatrist who is knowledgeable about mental institutions and other appropriate mental health and social service personnel;
2. The team must be supervised by a physician, but coordination of the team's activities remains the responsibility of the Division of Medicaid and Long-Term Care or their designee;
3. A member of the inspection of care team may not have a financial interest in any institution of the same type in which s/he is reviewing care but may have a financial interest in other facilities or institutions. A member of the inspection of care team may not review care in an institution where s/he is employed, but may review care in any other facility or institution.
4. A physician member of the team may not inspect the care of a client for whom s/he is the attending physician.
5. There must be a sufficient number of teams so located within the state that on-site inspections can be made at appropriate intervals in each facility caring for clients.

32-009.07B Frequency of Inspections: The inspection of care team and the Department shall determine, based on the quality of care and services being provided in a facility and the condition of clients in the facility, at what intervals inspections will be made. However, the inspection of care team shall inspect the care and services provided to each client at least annually, and/or more frequently as determined by the Inspection of Care team.

32-009.07C Notification Before Inspection: No facility may be notified of the time of inspection more than 48 hours before the scheduled arrival of the inspection of care team. The review team may make unannounced inspections at their discretion.

32-009.07D Personal Contact With and Observation of Recipients and Review of Records: For clients age 20 and younger, the team's inspection must include -

1. Personal contact with and observation of each client;
2. Review of each client's medical record; and
3. Review of the facility's policies as they pertain to direct patient care for each client being reviewed in the inspection of care, in accordance with 42 CFR 456.611(b)(1).

32-009.07E Determinations by the Team: The inspection of care team shall determine in its inspection whether -

1. The services available in the IMD are adequate to -
   a. Meet the health needs of each client; and
   b. Promote his/her maximum physical, mental, and psychosocial functioning;
2. It is necessary and desirable for the client to remain in the IMD;
3. It is feasible to meet the client's health needs through alternative institutional or noninstitutional services; and
4. Each client age 20 or younger in a psychiatric facility is receiving active treatment as defined in 42 CFR 441.154 and 471 NAC 32-009.05.

If, after an inspection of care is complete, the inspection of care team determines that a follow-up visit is required to ensure adequate care, a follow-up visit may be initiated by the team. This will be determined by the inspection of care team and will be noted in the inspection of care report.

32-009.07F Basis for Determinations: Under 42 CFR 456.610, in making the determinations by the team on the adequacy of services and other related matters, the team will determine what items will be considered in the review. This will include, but is not limited to, items such as whether -

1. The psychiatric and medical evaluation, any required social and psychological evaluations, and the plan of care are complete and current; the plan of care, and when required, the plan of rehabilitation are followed; and all ordered services, including dietary orders, are provided and properly recorded.;
2. The attending physician reviews prescribed medications at least every 30 days;
3. Test or observations of each client indicated by his/her medication regimen are made at appropriate times and properly recorded;
4. Physician, nurse, and other professional progress notes are made as required and appear to be consistent with the observed condition of the client;

5. The client receives adequate services, based on such observations as -
   a. Cleanliness;
   b. General physical condition and grooming;
   c. Mental status;
   d. Apparent maintenance of maximum physical, mental, and psychosocial function;
6. The client receives adequate rehabilitative services, as evidenced by -
   a. A planned program of activities to prevent regression; and
   b. Progress toward meeting objectives of the plan of care;
7. The client needs any services that are not furnished through the IMD or through arrangements with others;
8. The client needs continued placement in the IMD or there is an appropriate plan to transfer the client to an alternate method of care, which is the least restrictive, most appropriate environment that will still meet the client's needs.
9. Involvement of families and/or legal guardians (see 471 NAC 32-001); and
10. The facility's standards of care and policy and procedure meets the requirements for adequacy, appropriateness, and quality of services as they relate to individual Medicaid clients, as required by 42 CFR 456.611(b)(1).

32-009.07G Reports on Inspections: The inspection of care team shall submit a report to the Administrator of the Medicaid Division on each inspection. The report must contain the observations, conclusions, and recommendations of the team concerning -

1. The adequacy, appropriateness, and quality of all services provided in the IMD or through other arrangements, including physician services to clients; and
2. Specific findings about individual clients in the IMD.

The report must include the dates of the inspection and the names and qualifications of the team members. The report must not contain the names of clients; codes must be used. The facility will receive a copy of the codes.

32-009.07H Copies of Reports: Under 42 CFR 456.612, the Department shall send a copy of each inspection report to -

1. The facility inspected;
2. The IMD's utilization review committee;
3. The Nebraska Department of Health and Human Services, Division of Public Health; and
4. The Nebraska Department of Health and Human Services, Division of Behavioral Health.

If abuse or neglect is suspected, Medicaid staff shall make a referral to the appropriate investigative body.

32-009.07J Facility Response: Within 15 days following the receipt of the inspection of care team's report, the IMD shall respond to the Central Office in writing, and shall include the following information in the response:

1. A reply to any inaccuracies in the report. Written documentation to substantiate the inaccuracies must be sent with the reply. The Department will take appropriate action to note this in a follow-up response to the facility;
2. A complete plan of correction for all identified Findings and Recommendations;
3. Changes in level of care or discharge of individual clients;
4. Action to individual client recommendations; and
5. Projected dates of completion on each of the above.

If additional time is needed, the facility may request an extension.

At the facility's request, copies of the facility's response will be sent to all parties who received a copy of the inspection report in 471 NAC 32-009.07H.

A return site visit may occur after the written response is received to determine if changes have completely addressed the review team's concerns from the IOC report.

The Department will take appropriate action based on confirmed documentation on inaccuracies.

32-009.07K Department Action on Reports: The Department will take corrective action as needed based on the report and recommendations of the team submitted under this subpart.

32-009.07L Appeals: See 471 NAC 2-003 ff. and 465 NAC 2-001.02 ff. and 2-006 ff.

32-009.07M Failure to Respond: If the IMD fails to submit a timely and/or appropriate response, the Department may take administrative sanctions (see 471 NAC 2-002 ff.) or may suspend NMAP payment for an individual client or the entire payment to the facility.

32-009.08 Inpatient Mental Health Services for Individuals Age 20 and Younger in an IMD: NMAP covers inpatient mental health services in an IMD for individuals age 20 and younger under 42 CFR 440.160. The following requirements must be met to receive NMAP payment for these services.

32-009.08A Admission Criteria: See 471 NAC 32-008.05.

32-009.08B Admission Evaluation: A psychiatrist shall make an admission evaluation when the client is admitted to the hospital. The admission evaluation must include -

1. An initial assessment, within 24 working hours of the admission, of the health status and related psychological, medical, social, and educational needs of each individual client;
2. A determination of the range and kind of services required; and
3. If all admission criteria have been met, this evaluation must include an initial treatment plan.

32-009.08C Treatment Plan Requirements:

1. The treatment plan must meet the guidelines in 471 NAC 32-001 and in 42 CFR 441.155 and 441.156; and
2. The treatment plan must be developed by the psychiatrist and the Interdisciplinary Team defined in 471 NAC 32-009.08H.

32-009.08C1 Review of Plan of Care: Under 42 CFR 441.155(c), the facility interdisciplinary team shall review the plan of care every 30 days to -

1. Determine that services being provided are or were required on an inpatient basis; and
2. Recommend changes in the plan of care as indicated by the client's overall adjustment as an inpatient.

This review also serves as the recertification of need for services.

The individual plan of care must be developed by the facility interdisciplinary team.

32-009.08D Prior Authorization Procedures: IMD services for clients age 20 and younger must be prior-authorized as follows:

1. The psychiatrist/physician shall complete, sign, and date Form MC-14 within 48 hours after admission or at the time of application for medical assistance if this date is later than the date of admission. The 48-hour period does not include weekends or holidays. Copies of the admission notes and plan of care may be attached to the signed and dated Form MC-14 to certify that inpatient services are or were needed.
2. The facility shall contact the client's local office for determination of medical eligibility. The local office shall respond to the facility with -
   a. The medical eligibility effective date; and
   b. The date eligibility was determined, if this date is later than the date of admission.
3. The facility shall complete Form MC-9H, attach a copy of the completed Form MC-14, and forward to the Division of Medicaid and Long-Term Care. The facility shall retain the original copy of Form MC-14 in the client's medical record.
4. The Division of Medicaid and Long-Term Care shall review Form MC-14 and approve or reject the Form MC-14 findings within 15 days.
5. If rejected, the Division of Medicaid and Long-Term Care shall return all forms to the facility with an explanation of the rejection.
6. If approved, the Division of Medicaid and Long-Term Care shall complete Block #11 and the signature Block #18 of Form MC-9H. The white copy is retained in Central Office. The Central Office shall send the pink and gold copies to the facility and the yellow copy to the local office.
7. The document number on Form MC-9H must be entered in Form Locator 63 on each Form CMS-1450 or standard electronic Health Care Claim: Institutional transaction submitted to the Department. One carbon copy of Form MC-9H may be attached to the first claim submitted.
8. When the client is discharged or expires, the facility shall complete Form MC-10 to close the authorization. The facility shall forward the white copy to the Central Office and the yellow copy to the local office, and retain the pink and gold copies. Within 48 hours after a client is discharged or expires, the facility shall notify the client's local office.

32-009.08D1 Transfers: Transfer to another IMD or a readmission constitutes a new admission for the receiving facility. This procedure must be followed for each transfer or readmission.

32-009.08E Certification of Need for Services: For persons becoming Medicaid eligible after admission, in accordance with 42 CFR 441.152, the facility interdisciplinary team shall certify that -

1. Ambulatory care resources available in the community do not meet the treatment needs of the client;
2. Proper treatment of the client's psychiatric conditions requires services on an inpatient basis under the direction of a psychiatrist; and
3. The services can reasonably be expected to improve the client's condition or prevent further regression so that the services will no longer be needed.

The certification must be made at the time of admission, or if the individual applies for the NMAP while in the IMD, before the Department authorizes payment. This is accomplished by completion of Form MC-14. The form must be signed by the team physician/psychiatrist making the determination. A copy of the physician referral must accompany the completed MC-14.

32-009.08F Initial Certification: A psychiatrist shall pre-certify, at the time of admission, that the client requires inpatient services in a psychiatric hospital. The psychiatrist shall complete Form MC-14 at the time of admission or within 48 hours of admission. If the individual applies for NMAP while in a psychiatric hospital, the psychiatrist shall certify the client's needs before the Department authorizes payment.

32-009.08G Sixty-Day Recertification: A psychiatrist shall recertify, in the client's record, the client's need for continued care in a mental hospital or need for alternative arrangements at least every 60 days after the initial certification.

32-009.08H Interdisciplinary Plan of Care: The psychiatrist and the facility interdisciplinary team shall develop and implement an individual written plan of care for each client within 48 hours after the client's admission. This plan of care must be placed in the client's chart when completed. The written plan of care must include -

1. Diagnoses, symptoms, complaints, and complications indicating the need for admission;
2. A description of the client's functional level;
3. Objectives;
4. Any orders for -
    a. Medications;
    b. Treatments;

c. Restorative and rehabilitative services;
d. Activities;
e. Therapies;
f. Social services;
g. Diet; and
h. Special procedures recommended for the client's health and safety;

5. Plans for continuing care, including review and modification of the plan of care;
6. Appropriate medical treatment in the IMD every 60 days;
7. Appropriate social services every 60 days; and
8. Plans for discharge, including referrals for outpatient follow-up care.

Care plans must address family involvement.

This requirement may be met by completion of Form MC-14, which is retained in the client's record.

32-009.08J Required Psychiatrist Services: The client must be treated by a psychiatrist at least six out of seven days, or frequently as medically necessary and the interaction must be documented in the client's medical record.

32-009.08K Facility Interdisciplinary Plan of Care Team Review: The attending or staff psychiatrist and other personnel involved in the client's care shall review each plan of care at least every 30 days. The client's record must contain documentation of the 30-day interdisciplinary team review.

32-009.08L Admission Evaluation: IMD staff shall develop an admission evaluation for each client within 30 days after the client's admission. This evaluation must be placed in the client's record when completed. The admission evaluation must include -

1. The Form MC-14 (see 471 NAC 32-009.08E).
2. A medical evaluation, including -
   a. Diagnosis;
   b. Summary of current medical findings;
   c. Medical history;
   d. Mental and physical functional capacity;
   e. Prognosis;
   f. The psychiatrist's recommendation concerning the client's admission to the mental hospital or the client's need for continued care in the mental hospital, if the client applies for NMAP while in the mental hospital;
3. A psychiatric evaluation;
4. A social evaluation;
5. An initial plan of care sufficient to meet the client's needs until the facility interdisciplinary team has developed the individual written plan of care.

32-009.08M Discharge Planning: The IMD shall make available to the psychiatrist current information on resources available for continued out-of-hospital care of patients and shall arrange for prompt transfer of appropriate medical and nursing information to ensure continuity of care upon the client's discharge. The IMD is responsible for discharge planning. In cooperation with community regional mental health programs, the IMD shall -

1. Initiate alternate care arrangements;
2. Assist in client transfer; and
3. Follow-up on the client's alternate care arrangements.

When the client is being transferred to a long term care facility (NF or ICF/MR), the facility's staff must be included in the discharge process and must receive appropriate and adequate medical and nursing information to ensure continuity of care. The IMD shall also contact the client's local office.

32-009.09 Payment for Inpatient Mental Health Services in an Institution for Mental Disease: See 471 NAC 10-010.03 ff., 32-008.09, and 32-008.12.

32-009.10 Other Regulations: In addition to the policies regarding mental health services, all regulations in the Nebraska Department of Health and Human Services Manual apply, unless stated differently in this section.